JEFFERSON COUNTY
HUMAN SERVICES DEPARTMENT
2012 ANNUAL REPORT

SERVING THE RESIDENTS OF JEFFERSON COUNTY

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JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
Serving the Residents of Jefferson County
1541 Annex Rd, Jefferson, WI 53549-9803
Ph: 920-674-3105 Fax: 920-674-6113

May, 2013

Dear Mr. Molinaro, County Board Chair,
Members of the Jefferson County Board of Supervisors,
Members of the Jefferson County Human Services Board,
Jefferson County citizens,
And other interested parties,

RE: Letter from the Director

I am delighted to present the 2012 Jefferson County Human Services Department annual report. Our report provides information on all our services, reviews goals for 2012, and heralds new goals for 2013. In this letter, I will briefly talk about each division and the pressing issues facing our Department.

- The Aging and Disability Resource Division provides services for people who are elderly or disabled. In 2012, the ADRC was recognized for very impressive consumer satisfaction and added a Dementia Care Specialist to the service array. In the fall of 2013, we will have a second Family Care Managed Care Organization available in Jefferson County. The ADRC will continue to determine eligibility and provide options counseling relating to Family Care and Partnership benefits for people who are elderly, physically disabled, and developmentally disabled.

- Our Administrative Services Division provides all the maintenance, support, and fiscal duties required to operate the department. This division will focus on our Compliance Program and implementing electronic health records in 2013.

- The Behavioral Health Division provides a full array of mental health and substance abuse services to a variety of consumers. This area saw an increase in the number of people seeking and needing services for acute and pervasive substance abuse issues, including heroin. In 2013 we intend to initiate a Substance Abuse Prevention Coalition.

- The Child and Family Division offers a diverse array of services for children and families. In 2013, we are pleased to be able to offer an Alternative Reponse program in the child welfare area, and more options for child permanency through the Permanency Round Table meetings and our Safety grant initiative.

- The Income Maintenance Division provides resources for low income households and those experiencing financial loss. In 2013, this division, along with the Southern Income Maintenance Consortium, will provide the entry into the Accountable Care market exchanges as well determine Medicaid eligibility.

As you read our report, you will find each team's reviews of the goals established in 2012, and we are pleased to report that almost all goals were accomplished. Each team established new goals for 2013 based on what we are mandated to do and what our community needs. We also continue to use a continuous quality improvement model, called NIATx, to improve services, find efficiencies, and save money. We make every effort to uphold our pledge to deliver the best programs in the most cost effective manner for our citizens.

I thank our County Board Supervisors. We are ever grateful for your support.

I thank the members of our Human Services Board for their hard work and thoughtful consideration of many complex issues.

Lastly, I thank our dedicated employees, who continue to be responsive to the needs of our citizens.

Thank you,

Kathi Cauley
Director
Jefferson County Human Services

JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT

MISSION STATEMENT

Enhance the quality of life for individuals and families living in Jefferson County,
by addressing their needs in a respectful manner,
and enabling citizens receiving services to function as independently as possible
while acknowledging their cultural differences.

VISION STATEMENT

All citizens have the opportunity to access effective and comprehensive
human services in an integrated and efficient manner.

HUMAN SERVICES BOARD OF DIRECTORS
2012 – 2013

Jim Mode, *Chair*

Pam Rogers, *Vice Chair*

Richard Jones, *Secretary*

Augie Tietz

John McKenzie

Julie Merritt

James Schultz

ADVISORY COMMITTEE MEMBERS

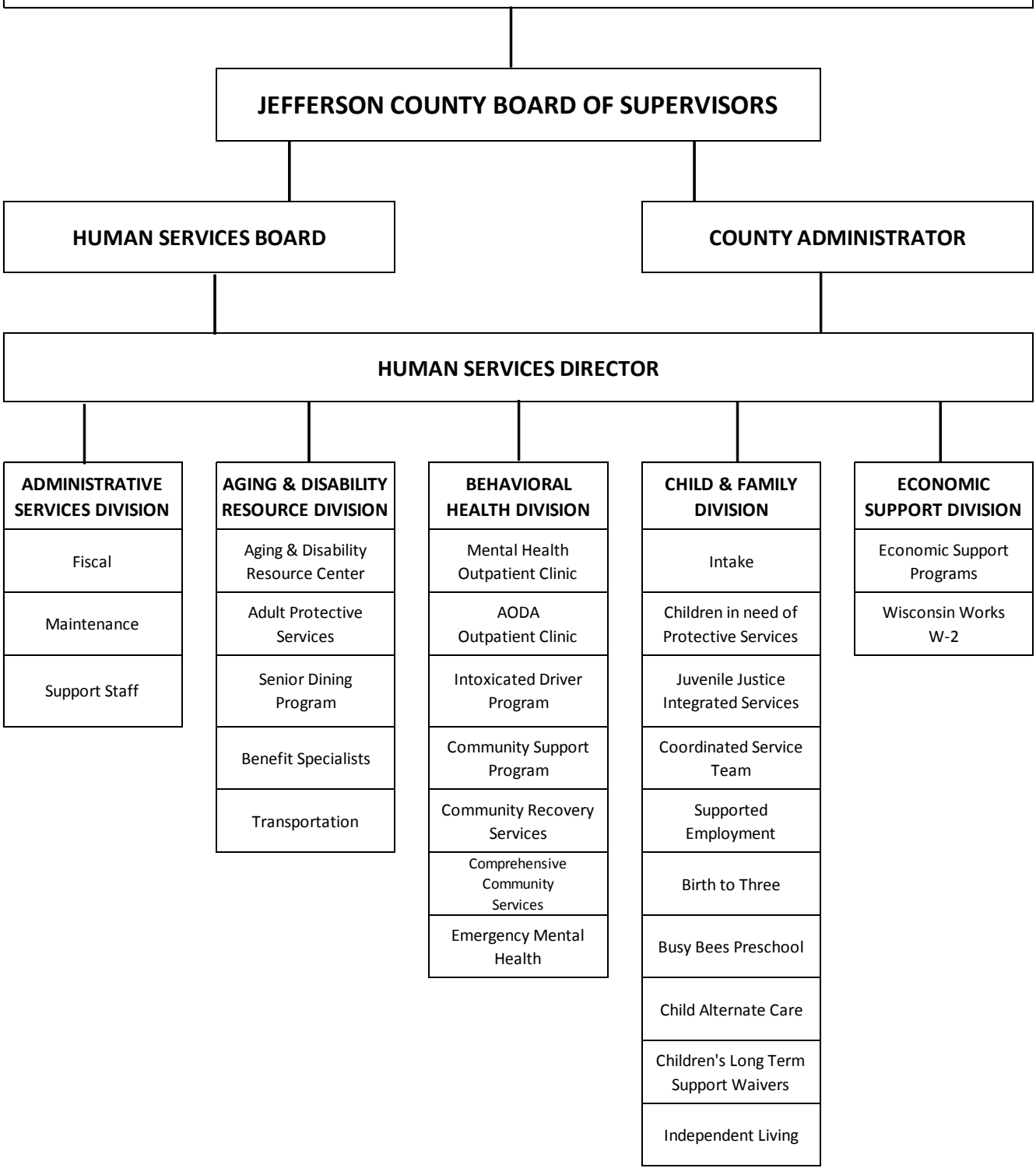
AGING AND DISABILITY RESOURCE CENTER ADVISORY COMMITTEE

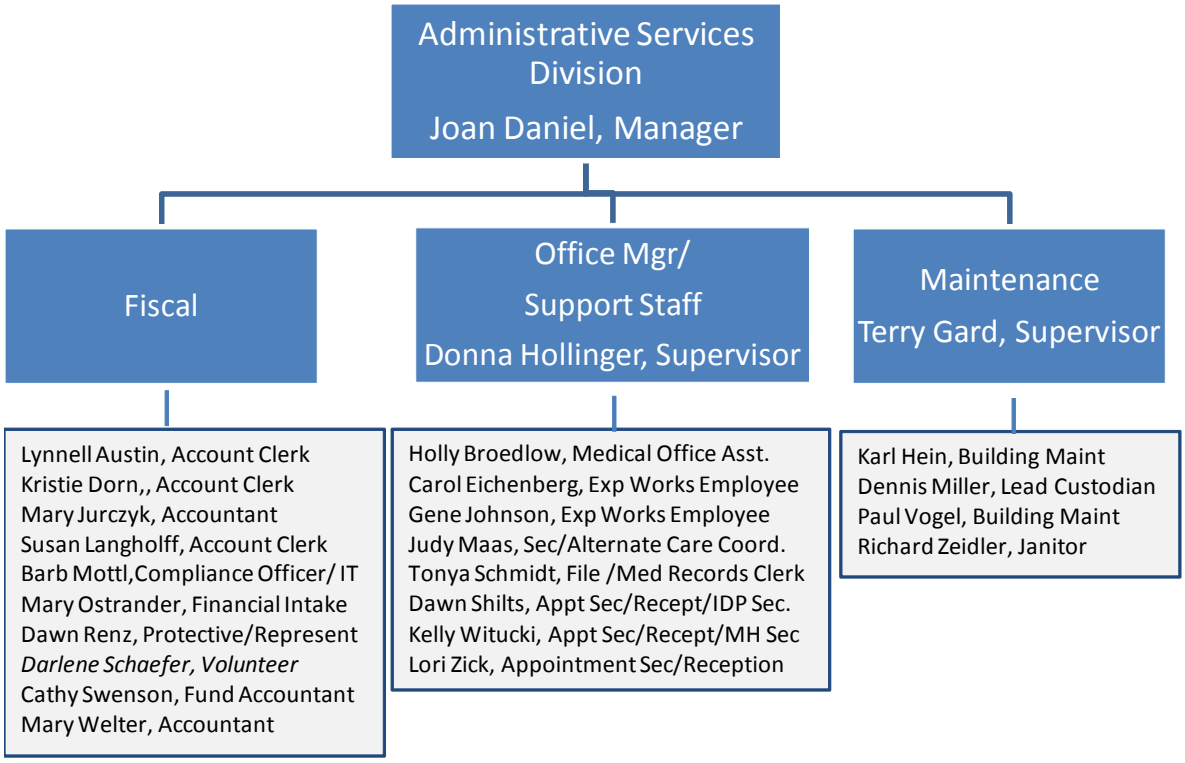
Nancy Haberman, Chair
Leah Getty
Richard Jones
Virgene Lawson
Jim Mode
Marion Moran
Mike Mullenax
Mary Ann Steppke
Sharon Van Acker
Sue Torum, Staff
Sharon Olson, Staff

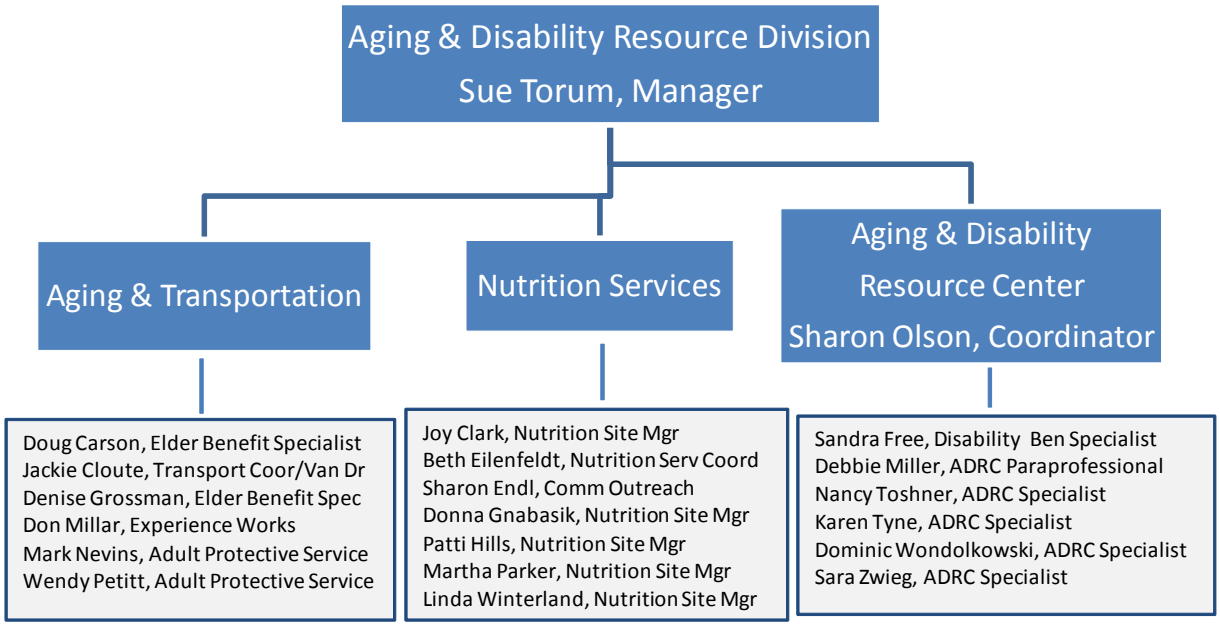
NUTRITION PROJECT COUNCIL

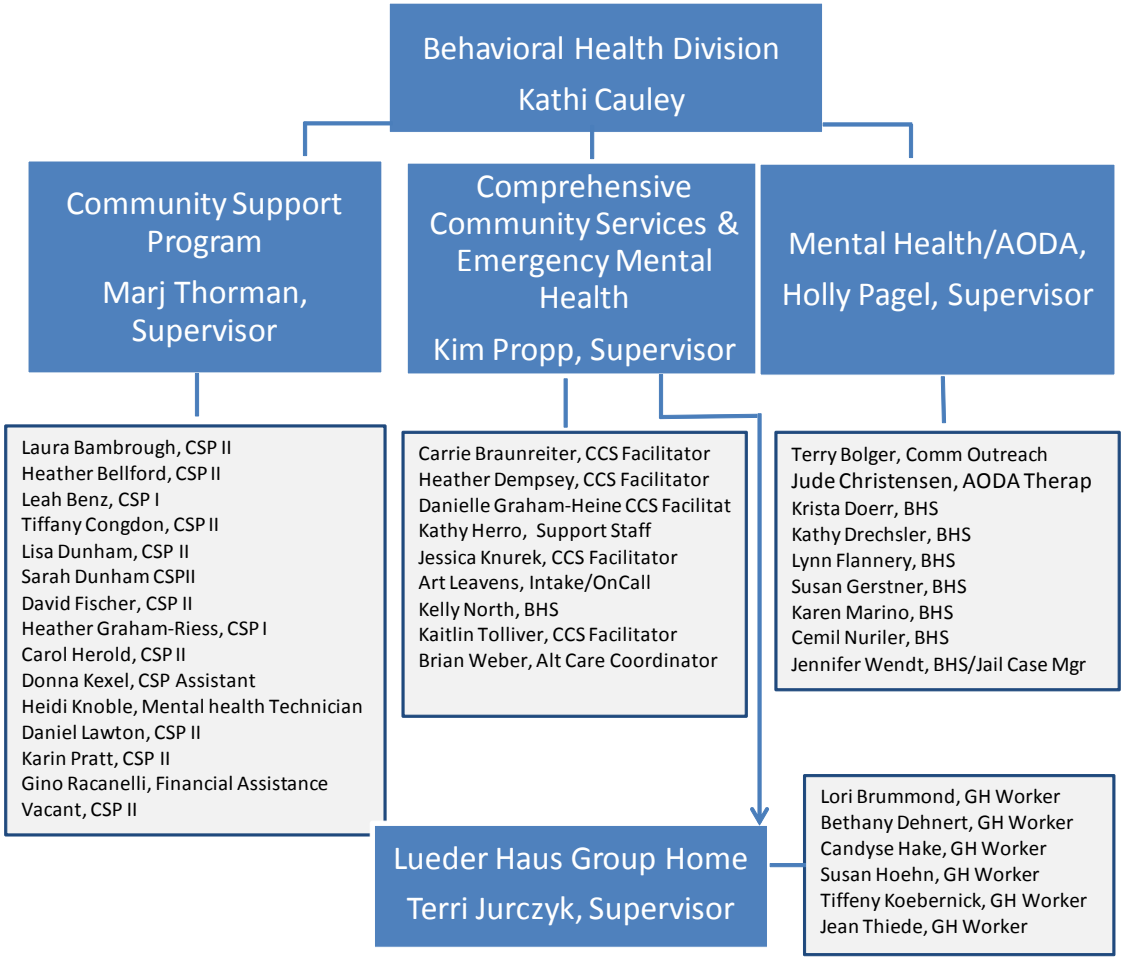
Marcia Bare
Dorothy Christianson
Rita Kannenberg
Carolyn McCleery
Judy Pinnow
Audrey Remmel
Joan Simdon
Barbara Natrop

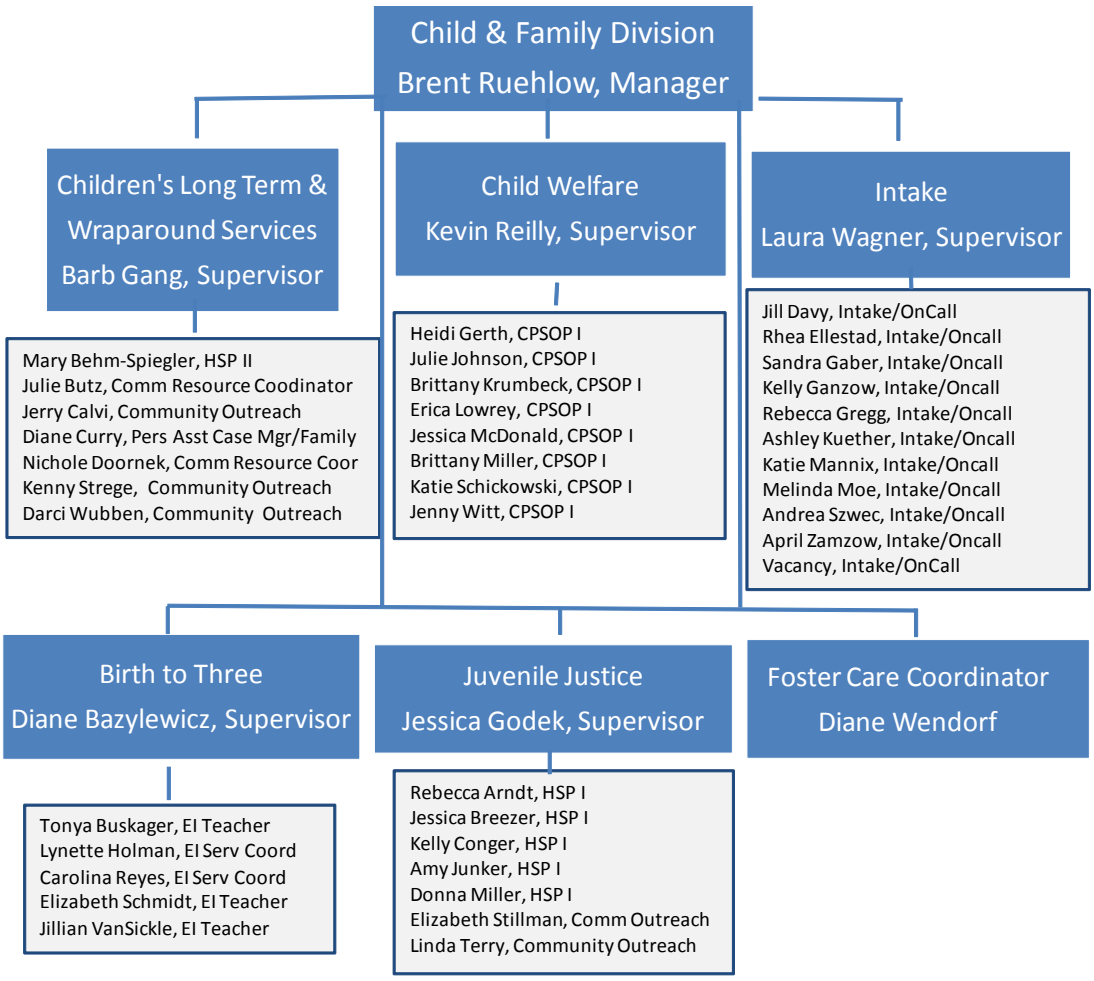
JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT ORGANIZATIONAL CHART

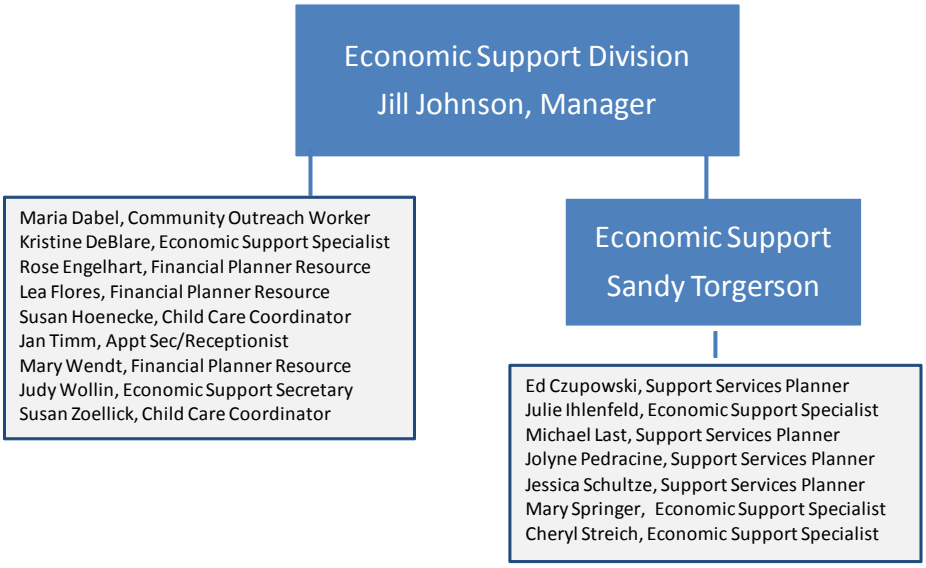



Administrative Services Division
Joan Daniel, Manager
Fiscal
Office Mgr/ Support Staff
Donna Hollinger, Supervisor
Maintenance
Terry Gard, Supervisor
Lynnell Austin, Account Clerk
Kristie Dorn,, Account Clerk
Mary Jurczyk, Accountant
Susan Langholff, Account Clerk
Barb Mottl,Compliance Officer/ IT
Mary Ostrander, Financial Intake
Dawn Renz, Protective/Represent
Darlene Schaefer, Volunteer
Cathy Swenson, Fund Accountant
Mary Welter, Accountant
Holly Broedlow, Medical Office Asst.
Carol Eichenberg, Exp Works Employee
Gene Johnson, Exp Works Employee
Judy Maas, Sec/Alternate Care Coord.
Tonya Schmidt, File /Med Records Clerk
Dawn Shilts, Appt Sec/Recept/IDP Sec.
Kelly Witucki, Appt Sec/Recept/MH Sec
Lori Zick, Appointment Sec/Reception
Karl Hein, Building Maint
Dennis Miller, Lead Custodian
Paul Vogel, Building Maint
Richard Zeidler, Janitor


Aging & Disability Resource Division
Sue Torum, Manager
Aging & Transportation
Nutrition Services
Aging & Disability Resource Center
Sharon Olson, Coordinator
Doug Carson, Elder Benefit Specialist
Jackie Cloute, Transport Coor/Van Dr
Denise Grossman, Elder Benefit Spec
Don Millar, Experience Works
Mark Nevins, Adult Protective Service
Wendy Petitt, Adult Protective Service
Joy Clark, Nutrition Site Mgr
Beth Eilenfeldt, Nutrition Serv Coord
Sharon Endl, Comm Outreach
Donna Gnabasik, Nutrition Site Mgr
Patti Hills, Nutrition Site Mgr
Martha Parker, Nutrition Site Mgr
Linda Winterland, Nutrition Site Mgr
Sandra Free, Disability Ben Specialist
Debbie Miller, ADRC Paraprofessional
Nancy Toshner, ADRC Specialist
Karen Tyne, ADRC Specialist
Dominic Wondolkowski, ADRC Specialist
Sara Zwieg, ADRC Specialist


Behavioral Health Division
Kathi Cauley
Community Support Program
Marj Thorman, Supervisor
Comprehensive Community Services & Emergency Mental Health
Kim Propp, Supervisor
Mental Health/AODA,
Holly Pagel, Supervisor
Laura Bambrough, CSP II
Heather Bellford, CSP II
Leah Benz, CSP I
Tiffany Congdon, CSP II
Lisa Dunham, CSP II
Sarah Dunham CSPII
David Fischer, CSP II
Heather Graham-Riess, CSP I
Carol Herold, CSP II
Donna Kexel, CSP Assistant
Heidi Knoble, Mental health Technician
Daniel Lawton, CSP II
Karin Pratt, CSP II
Gino Racanelli, Financial Assistance
Vacant, CSP II
Carrie Braunreiter, CCS Facilitator
Heather Dempsey, CCS Facilitator
Danielle Graham-Heine CCS Facilitat
Kathy Herro, Support Staff
Jessica Knurek, CCS Facilitator
Art Leavens, Intake/OnCall
Kelly North, BHS
Kaitlin Tolliver, CCS Facilitator
Brian Weber, Alt Care Coordinator
Terry Bolger, Comm Outreach
Jude Christensen, AODA Therap
Krista Doerr, BHS
Kathy Drechsler, BHS
Lynn Flannery, BHS
Susan Gerstner, BHS
Karen Marino, BHS
Cemil Nuriler, BHS
Jennifer Wendt, BHS/Jail Case Mgr
Lueder Haus Group Home
Terri Jurczyk, Supervisor
Lori Brummond, GH Worker
Bethany Dehnert, GH Worker
Candyse Hake, GH Worker
Susan Hoehn, GH Worker
Tiffeny Koebernick, GH Worker
Jean Thiede, GH Worker


Child & Family Division
Brent Ruehlow, Manager
Children's Long Term & Wraparound Services
Barb Gang, Supervisor
Mary Behm-Spiegler, HSP II
Julie Butz, Comm Resource Coodinator
Jerry Calvi, Community Outreach
Diane Curry, Pers Asst Case Mgr/Family
Nichole Doornek, Comm Resource Coor
Kenny Strege, Community Outreach
Darci Wubben, Community Outreach
Child Welfare
Kevin Reilly, Supervisor
Heidi Gerth, CPSOP I
Julie Johnson, CPSOP I
Brittany Krumbeck, CPSOP I
Erica Lowrey, CPSOP I
Jessica McDonald, CPSOP I
Brittany Miller, CPSOP I
Katie Schickowski, CPSOP I
Jenny Witt, CPSOP I
Intake
Laura Wagner, Supervisor
Jill Davy, Intake/OnCall
Rhea Ellestad, Intake/Oncall
Sandra Gaber, Intake/Oncall
Kelly Ganzow, Intake/Oncall
Rebecca Gregg, Intake/Oncall
Ashley Kuether, Intake/Oncall
Katie Mannix, Intake/Oncall
Melinda Moe, Intake/Oncall
Andrea Szwec, Intake/Oncall
April Zamzow, Intake/Oncall
Vacancy, Intake/OnCall
Birth to Three
Diane Bazylewicz, Supervisor
Tonya Buskager, EI Teacher
Lynette Holman, EI Serv Coord
Carolina Reyes, EI Serv Coord
Elizabeth Schmidt, EI Teacher
Jillian VanSickle, EI Teacher
Juvenile Justice
Jessica Godek, Supervisor
Rebecca Arndt, HSP I
Jessica Breezer, HSP I
Kelly Conger, HSP I
Amy Junker, HSP I
Donna Miller, HSP I
Elizabeth Stillman, Comm Outreach
Linda Terry, Community Outreach
Foster Care Coordinator
Diane Wendorf


Economic Support Division
Jill Johnson, Manager
Maria Dabel, Community Outreach Worker
Kristine DeBlare, Economic Support Specialist
Rose Engelhart, Financial Planner Resource
Lea Flores, Financial Planner Resource
Susan Hoenecke, Child Care Coordinator
Jan Timm, Appt Sec/Receptionist
Mary Wendt, Financial Planner Resource
Judy Wollin, Economic Support Secretary
Susan Zoellick, Child Care Coordinator
Economic Support
Sandy Torgerson
Ed Czupowski, Support Services Planner
Julie Ihlenfeld, Economic Support Specialist
Michael Last, Support Services Planner
Jolyne Pedracine, Support Services Planner
Jessica Schultze, Support Services Planner
Mary Springer, Economic Support Specialist
Cheryl Streich, Economic Support Specialist

ADMINISTRATIVE SERVICES DIVISION

Providing support, maintenance, and fiscal oversight to the Department

The Administrative Services Division provides support, maintenance, and fiscal oversight for the department. To complete the necessary work, there are three sections overseen by a division manager.

The fiscal team consists of nine full time employees, and one volunteer. They ensure that all accounting, billing for client insurance, protective payee payments, client financial ability to pay reviews, data tasks, and all financial reports are accomplished for the department.

The Maintenance team consists of a supervisor, four full time employees and one part time employee. They ensure that the buildings and grounds are in working order.

The Support Staff team consists of an Office Manager/Supervisor, six full time employees, and two part time staff who are employed through Experience Works. They ensure that phones are answered, appointments are scheduled, records are maintained and filed and all other support duties are completed.

ADMINISTRATIVE SERVICES TEAMS

Fiscal
Support Staff
Maintenance

FISCAL

~Ensuring fiscal responsibility to the citizens of Jefferson County~

Fiscal Statement Summary
December Final, 2012

Operations from 2012 resulted in a net surplus of $446,891 prior to moving prepaid insurance expenditures to the Balance Sheet in the amount of approximately $152,000 for a total of $598,891. The county board approved our request to carryover this money.

Summary of the variances from budget:
Overall Revenue was favorable by $247,684
Expenditures were under budget by $206,271
Net Savings (prior to prepaid insurance adjustment) $453,955

Three Major Classifications impacting the favorable balance:
Revenues:
State Revenues for the Children & Families had a favorable $71,106 balance (Meth Grant).
Collections from Provided Services and Cost Reimbursements were favorable by $127,677.

Fringe Benefits: The budget was prepared prior to employees having to cost share for insurance. Some employees discontinued purchasing insurance or changed plans resulting in a favorable balance of $273,434.

Note: Since 2009, annual savings for staff travel expenditures averaged $69,732.

FINANCIAL REPORTS

The Financial Reports that follows summarize Department resources and expenditures by source and type, by target group, and by service type. Data is presented in numeric and pie chart formats. Total resources for 2012, including County tax levy, were $18 18,635,344 Total expenditures were $18,425,647.

2012 Resources & Expenditures

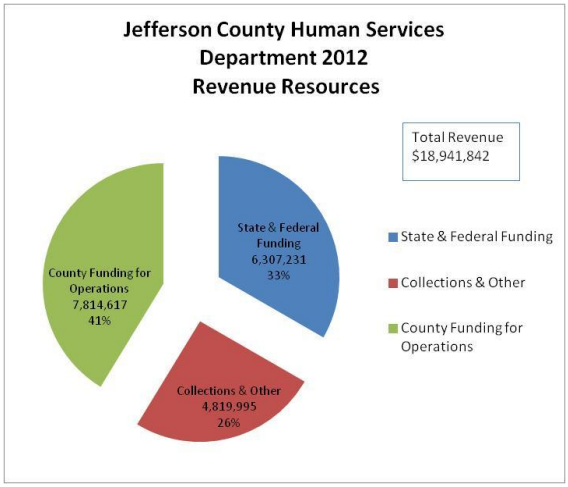
(unaudited)

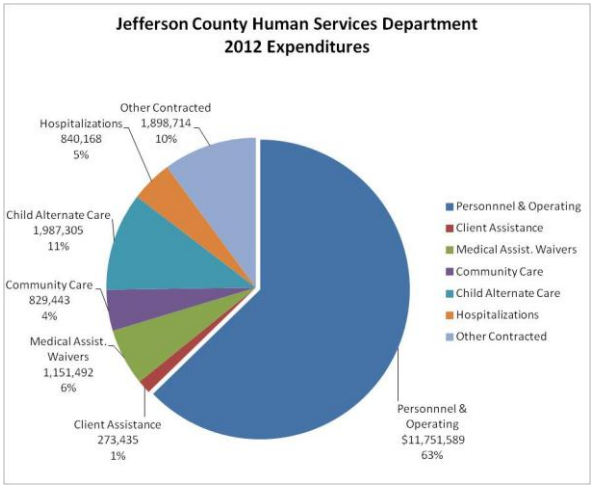
RESOURCES:	2011 ACTUAL	2012 ACTUAL	2012 BUDGET	2012 VARIANCE
State & Federal Funding	$ 8,097,644	$ 6,307,231	$ 7,682,846	$ (1,375,615)
Collections & Other	3,218,772	4,513,496	2,890,197	1,623,299
County Funding for Operations	7,975,355	7,814,617	7,814,617	0
Total Resources	$ 19,291,771	$ 18,635,344	$ 18,387,660	$453,955

EXPENDITURES:	2011 ACTUAL	2012 ACTUAL	2012 BUDGET	2012 VARIANCE
Personnnel & Operating	$ 11,671,595	$ 11,751,589	$ 12,254,984	$ 503,395
Client Assistance	565,131	273,435	364,954	91,519
Medical Assist. Waivers	803,371	844,993	716,792	(128,201)
Community Care	695,579	829,443	760,127	(69,316)
Child Alternate Care	1,492,351	1,987,305	1,737,511	(249,794)
Hospitalizations	684,571	840,168	804,614	(35,554)
Other Contracted	2,361,602	1,898,714	1,992,936	94,222
Total Expenditures	$ 18,274,200	$ 18,425,647	$ 18,631,918	$ 206,271

SUMMARY	2011 BALANCE	2012 BALANCE	2012 PERCENT of BUDGET
Surplus from operations	1,017,571	209,697	1.14%
2011 Carry Forward		237,194	
Total Net Surplus		446,891	2.40%
(Without Personnel Variance)	532,322	163,696	0.88%

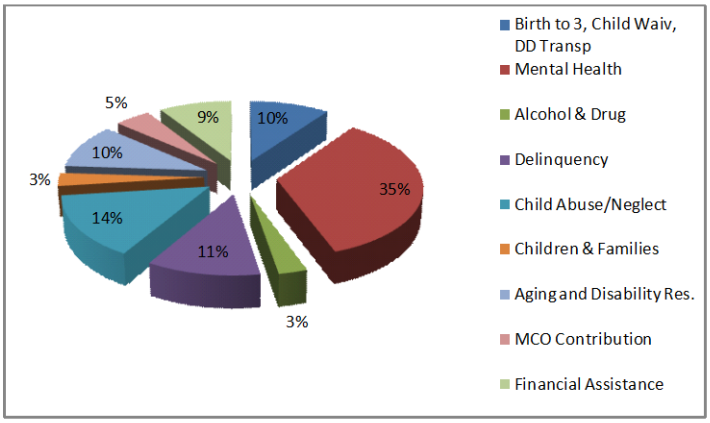
2012 operations resulted in a net surplus of $446,891 prior to moving prepaid insurance (1$166,038) to the Balance Sheet (2.40% of total budget), which $0 was lapsed into the County General Fund; Non Lapsing Request for 2012 - $599,147 was approved





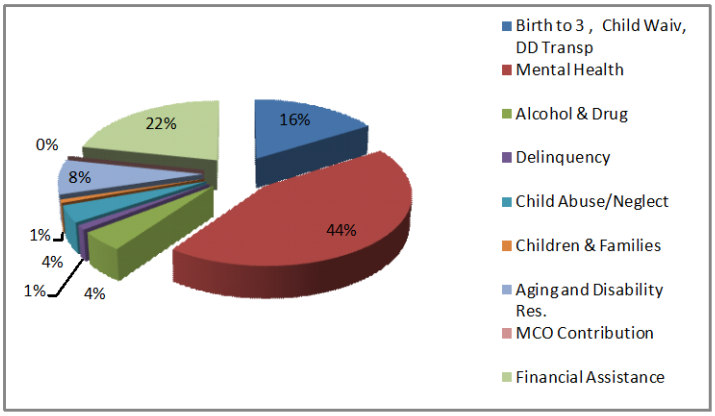
2012 Costs by Target Group

Total Expenditures	
Birth to 3, Child Waiv, DD Transp	1,887,156
Mental Health	6,534,875
Alcohol & Drug	537,918
Delinquency	2,124,456
Child Abuse/Neglect	2,742,702
Children & Families	572,175
Aging and Disability Res.	1,952,747
MCO Contribution	858,734
Financial Assistance	1,722,531
TOTAL	18,933,294

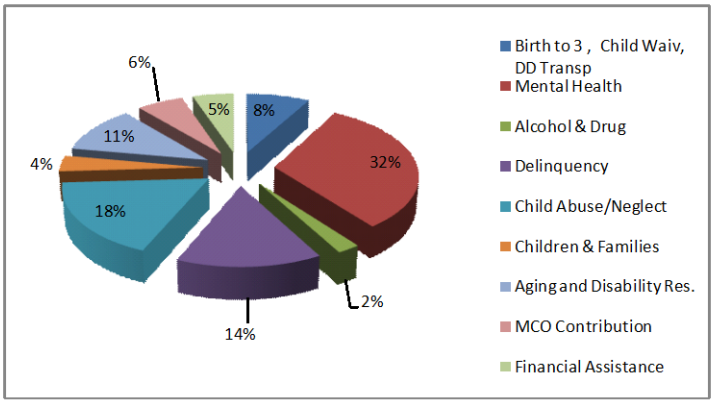


Collections & Donations	
Birth to 3 , Child Waiv, DD Transp	722,469
Mental Health	1,962,236
Alcohol & Drug	204,047
Delinquency	49,505
Child Abuse/Neglect	176,113
Children & Families	33,371
Aging and Disability Res.	359,756
MCO Contribution	0
Financial Assistance	968,475
TOTAL	4,475,972

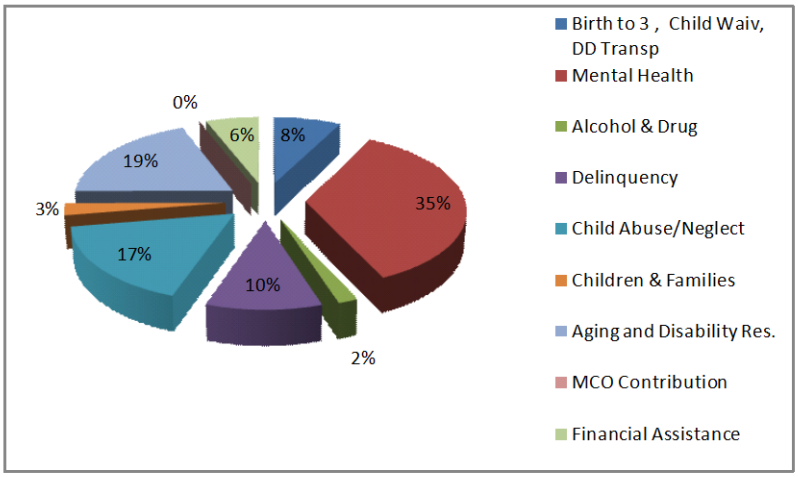
Note: Switched to WPS payments versus state paying for services provided by Jefferson County HSD.



Net Costs	
Birth to 3 , Child Waiv, DD Transp	1,164,687
Mental Health	4,572,639
Alcohol & Drug	333,871
Delinquency	2,074,951
Child Abuse/Neglect	2,566,589
Children & Families	538,804
Aging and Disability Res.	1,592,991
MCO Contribution	858,734
Financial Assistance	754,056
TOTAL	14,457,322

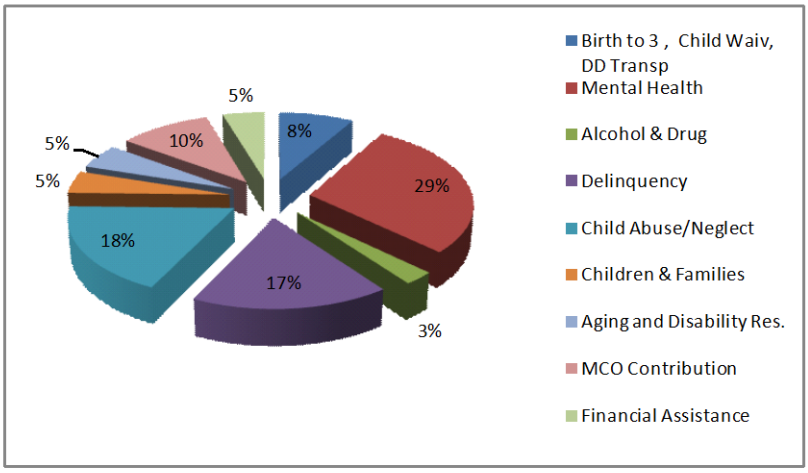


State & Federal Funding	
Birth to 3 , Child Waiv, DD Transp	468,202
Mental Health	2,180,078
Alcohol & Drug	109,299
Delinquency	636,533
Child Abuse/Neglect	1,049,559
Children & Families	155,672
Aging and Disability Res.	1,170,752
MCO Contribution	0
Financial Assistance	368,171
TOTAL	6,138,267



Note: Funding for Waiver changed from state to WPS - classified as collections

Net County Cost	
Birth to 3 , Child Waiv, DD Transp	696,485
Mental Health	2,392,561
Alcohol & Drug	224,572
Delinquency	1,438,418
Child Abuse/Neglect	1,517,030
Children & Families	383,132
Aging and Disability Res.	422,239
MCO Contribution	858,734
Financial Assistance	385,885
TOTAL	8,319,055



NOTE Calculation of Levy	
Note Budget Tax Levy	7,814,617
General Fund & Non Lapsing	0
Depreciation	169,869
County Indirect Cost	334,569
Tax levy	8,319,055

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers.

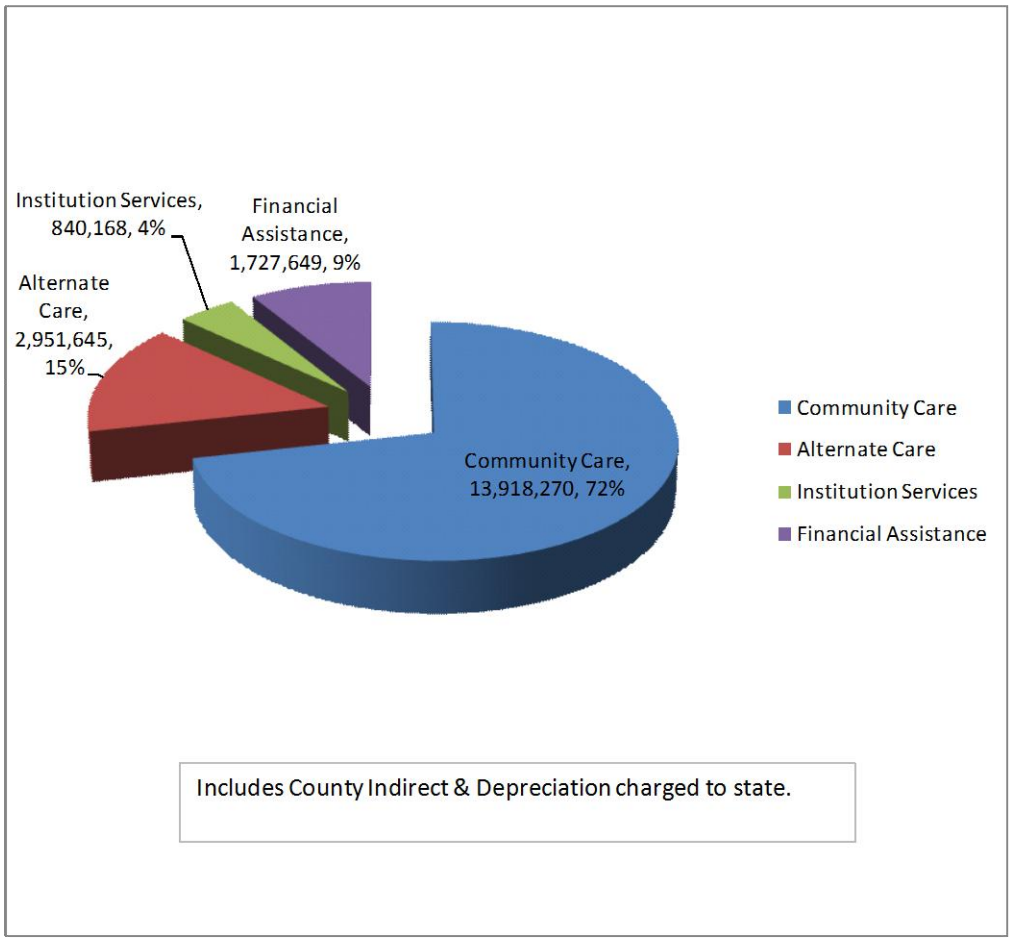
The graph below indicates the following:

- Community Care includes all Behavioral Health and Family Resource Services.
- Alternate Care includes all costs for Children and Adults.
- Institution Services include all inpatient services for children and adults, and juvenile corrections.
- Financial Assistance includes all of Income Maintenance costs.

2012 Costs by Service Type

Total Expenditures	
Community Care	13,918,270
Alternate Care	2,951,645
Institution Service	840,168
Financial Assistanc	1,727,649
TOTAL	18,933,294

***Includes County Indirect Costs & Depreciation charged to state**



Over the last 4 years, we have endeavored to review all department systems for cost savings. The vehicle expense chart below is one example. In 2009, mileage paid to staff was $269,112. Over the last three years, we added additional vehicles and have seen an average savings of approximately $70,000 per year, even with additional vehicle expenses. The chart below summarizes this data with 2009 being the base year.

4 Year Comparison of Mileage and Vehicle Expenses				
	2009	**2010**	**2011**	**2012**
Total Mileage	$269,112	$180,174	$155,922	$160,553
Gas/Diesel	$16,464	$20,604	$32,298	$41,206
Non Capital Auto	$8	$9,001	$13,007	$9,509
Sale Squad Vehicles	$0	$0	-$1,495	-$1,988
Vehicle Parts & Repairs	$5,837	$11,413	$16,910	$17,954
TOTAL EXPENSE	$291,421	$221,192	$216,642	$227,234
SAVINGS COMPARED TO BASE YEAR	**-**	**$70,229**	**$74,779**	**$64,187**

DONATIONS & GRANTS			
DONATIONS	**Amount**		**Program**
Anonymous	$	300.00	General
Citizen Donation	$	2,000.00	Benefit Specialist
Spacesaver	$	250.00	Wraparound
Helen Davis Foundation	$	100.00	Incredible Years
TOTAL DONATIONS	**$**	**2,650.00**	

GRANTS	**Amount**		**Program**
United Way of Jefferson & Walworth Counties	$	738.00	Incredible Years
United Way of Jefferson & Walworth Counties	$	512.00	Incredible Years
United Way of Jefferson & Walworth Counties	$	625.00	Incredible Years
United Way of Jefferson & Walworth Counties	$	625.00	Incredible Years
Watertown Area United Way	$	2,900.00	Birth to 3
Watertown Area United Way	$	3,100.00	Birth to 3
Watertown Area United Way	$	120.00	Wraparound
Watertown Area United Way	$	375.00	Wraparound
TOTAL GRANTS	**$**	**8,995.00**	

TOTAL DONATIONS & GRANTS	**$ 11,645.00**

Human Services Department Five Year Comparison of Costs

MANAGEMENT	2008	2009	2010	2011	2012	2008	2009	2010	2011	2012
Expenditure										
Wages - Regular	557,597	517,376	396,555	461,965	499,950	100%	92.79%	71.12%	82.85%	89.66%
Wages-Overtime	5,980	0	0	905	0	100%	0.00%	0.00%	15.13%	0.00%
Wages-Regular Overtime	357	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%
Wages-Sick Leave	28,440	65,935	24,852	14,836	15,024	100%	231.84%	87.38%	52.17%	52.83%
Wages-Vacation Pay	55,358	71,251	34,431	43,036	44,160	100%	128.71%	62.20%	77.74%	79.77%
Wages-Longevity Pay	3,122	2,866	1,253	1,973	2,424	100%	91.78%	40.13%	63.20%	77.64%
Wages-Holiday Pay	24,839	23,378	20,329	19,202	22,912	100%	94.12%	81.84%	77.31%	92.24%
Wages-Miscellaneous(Comp)	6,494	8,939	17,743	17,536	18,371	100%	137.64%	273.22%	270.03%	282.89%
Wages-Bereavement	764	509	599	1,022	0	100%	66.66%	78.40%	133.77%	0.00%
Wages-Death Benefit	1,839	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%
Social Security	52,405	54,208	38,058	42,774	45,427	100%	103.44%	72.62%	81.62%	86.68%
Retirement (Employer)	31,432	28,281	23,005	30,341	35,801	100%	89.98%	73.19%	96.53%	113.90%
Retirement (Employee)	40,958	37,015	29,664	21,012	-7	100%	90.37%	72.43%	51.30%	-0.02%
Health Insurance	221,462	212,410	146,728	142,478	136,585	100%	95.91%	66.25%	64.34%	61.67%
Life Insurance	452	400	276	299	335	100%	88.43%	61.06%	66.15%	74.12%
Dental Insurance	10,141	10,046	7,618	9,138	8,960	100%	99.06%	75.12%	90.11%	88.35%
Per Diem	7,480	7,530	6,325	5,720	6,545	100%	100.67%	84.56%	76.47%	87.50%
Advertising	0	303	0		47	100%				
Board Member Training	611	465	775	690	509	100%	76.10%	126.84%	112.93%	83.31%
Registration	1,607	565	874	1,315	2,046	100%	35.16%	54.39%	81.83%	127.32%
Mileage	4,949	3,887	3,545	3,524	4,520	100%	78.55%	71.63%	71.21%	91.33%
Other Insurance		3,540	2,692		0	100%				
MANAGEMENT	**1,056,287**	**1,048,903**	**755,322**	**817,766**	**843,609**	**100%**	**99.30%**	**71.51%**	**77.42%**	**79.87%**
Maintenance Personnel										
Expenditure										
Wages - Regular	227,723	180,279	187,961	197,162	199,615	100%	79.17%	82.54%	86.58%	87.66%
Wages-Sick Leave	9,330	1,718	3,436	2,164	2,544	100%	18.41%	36.83%	23.19%	27.27%
Wages-Vacation Pay	14,139	14,923	14,951	14,095	14,620	100%	105.54%	105.74%	99.69%	103.40%
Wages-Longevity Pay	844	751	786	1,156	1,201	100%	89.01%	93.13%	136.97%	142.30%
Wages-Holiday Pay	6,874	7,118	8,439	7,119	7,694	100%	103.55%	122.77%	103.56%	111.93%
Wages-Miscellaneous(Comp)	2,287	924	916	1,945	2,217	100%	40.41%	40.05%	85.05%	96.94%
Wages-Bereavement	524	0	542	1,476	0	100%	0.00%	103.44%	281.68%	0.00%
Sub total Wages	**261,721**	**205,713**	**217,031**	**225,117**	**227,891**	**100%**	**78.60%**	**82.92%**	**86.01%**	**87.07%**
Social Security	20,419	16,212	16,680	17,197	17,232	100%	79.39%	81.69%	84.22%	84.39%
Retirement (Employer)	11,240	9,557	10,140	12,155	13,515	100%	85.03%	90.21%	108.14%	120.24%
Retirement (Employee)	14,661	12,524	13,090	8,452	0	100%	85.42%	89.28%	57.65%	0.00%
Health Insurance	55,859	62,345	69,751	62,736	43,297	100%	111.61%	124.87%	112.31%	77.51%
Life Insurance	80	123	123	128	130	100%	153.25%	153.75%	160.00%	162.50%
Dental Insurance	2,388	2,944	3,431	3,424	3,257	100%	123.28%	143.68%	143.38%	136.39%
Maintenance Personnel Cost	**366,368**	**309,418**	**330,246**	**329,209**	**305,322**	**100%**	**84.46%**	**90.14%**	**89.86%**	**83.34%**
Overhead										
Unemployment Compensation	(62)	787	22,574	11,537	10,060	100%	-1269.03%	-36409.68%	-18608.06%	-16225.81%
Workers Compensation	2,356	6,213	29,354	28,635	10,588	100%	263.70%	1245.93%	1215.41%	449.41%
Legal	2,271	3,548	3,451	4,705	6,648	100%	156.25%	151.96%	207.18%	292.73%
Accounting & Auditing	10,801	16,349	16,546	17,199	18,566	100%	151.37%	153.19%	159.24%	171.89%
Other Professional Serv	2,400	88	0	0	0	100%	3.67%	0.00%	0.00%	0.00%
Computer Support	825	0	5,392	5,311	1,856	100%	0.00%	653.58%	643.76%	224.97%
Clearing House Services				1,844	3,462				100.00%	100.00%
Grounds Keeping Charges	7,138	8,841	10,700	14,994	13,649	100%	123.86%	149.90%	210.06%	191.22%
Purchase Care & Services	0	0	83		0	100%				
Computer Equipment	46,243	2,834	32,147	46,223	45,831	100%	6.13%	69.52%	99.96%	99.11%
Noncapital Auto	12,000	8	9,001	13,007	9,509	100%	0.07%	75.01%	108.39%	79.24%
Office 2007 Upgrade	33,168	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%
Postage & Box Rent	22,672	29,815	950	21,585	25,563	100%	131.51%	4.19%	95.21%	112.75%
Office Supplies	46,935	41,279	40,517	41,434	43,548	100%	87.95%	86.33%	88.28%	92.78%
Printing & Duplicating	2,413	6,552	6,955	10,429	12,427	100%	271.53%	288.23%	432.20%	515.00%
Small Items Of Equip	2,802	730	139	1,503	8,745	100%	26.05%	4.96%	53.64%	312.10%
Instructional Material	382	0	89	158	0	100%	0.00%	23.30%	41.36%	0.00%
Membership Dues	1,593	1,461	950	1,180	1,585	100%	91.71%	59.64%	74.07%	99.50%
Advertising	12,111	5,269	4,055	7,381	7,476	100%	43.51%	33.48%	60.94%	61.73%
Educational Supplies	935	464	154	0	865	100%	49.63%	16.47%	0.00%	92.51%
Other Operating Expenses	2,585	2,413	20	820	55	100%	93.35%	0.77%	31.72%	2.13%
Gasoline, Oil, Fuel	16,257	14,150	18,255	28,759	37,501	100%	87.04%	112.29%	176.90%	230.68%
Water	4,516	4,574	4,618	4,459	4,483	100%	101.28%	102.26%	98.74%	99.27%
Electric	68,905	68,502	75,944	72,773	74,852	100%	99.42%	110.22%	105.61%	108.63%
Sewer	4,104	4,202	4,335	4,331	4,467	100%	102.39%	105.63%	105.53%	108.85%
Natural Gas	34,402	29,997	25,622	23,532	19,558	100%	87.20%	74.48%	68.40%	56.85%
Telephone & Fax	49,248	44,464	46,147	49,090	50,750	100%	90.29%	93.70%	99.68%	103.05%
Internet	943	1,072	1,391	1,284	1,286	100%	113.68%	147.51%	136.16%	136.37%
Storm Water Utility	1,630	2,133	2,133	1,509	2,133	100%	130.86%	130.86%	92.58%	130.86%
Wireless Internet				6,204	27,452				100.00%	442.49%
Maintain Machinery & Equip	43,637	34,414	26,958	36,042	51,810	100%	78.86%	61.78%	82.60%	118.73%
Ground & Ground Improvement	360	211	9,226	12,490	7,292	100%	58.61%	2562.78%	3469.44%	2025.56%
Bldg Repair & Maint			1,440	1,440	3,209	100%		100.00%	100.00%	222.85%
Refuse Collection			3,568	3,795	3,449	100%		100.00%	106.36%	96.66%
Household & Janitorial Supp	17,040	14,689	14,105	17,459	17,734	100%	86.20%	82.78%	102.46%	104.07%
Other Supplies				277	0				100.00%	
Vehicle Parts & Repairs	7,074	5,837	11,413	16,910	17,699	100%	82.51%	161.34%	239.04%	250.20%
Repair & Maintenance	25,305	22,338	18,797	28,897	44,487	100%	88.28%	74.28%	114.19%	175.80%
Green Initiatives				23,721	4,466				100.00%	18.83%
Data Processing Inter-D	186,370	300,578	224,152	276,266	306,116	100%	161.28%	120.27%	148.24%	164.25%
I.P. Telephony	23,456	74,748	24,358	19,069	21,844	100%	318.67%	103.85%	81.30%	93.13%
Duplicating Allocation		8,818	6,595	4,654	7,141		100%	74.79%	52.78%	80.98%
Other Insurance	85,900	9,071	8,631	46,541	44,898	100%	10.56%	10.05%	54.18%	52.27%
Prior Year Expenditures	0	(4,390)	0	-207		100%				
Miscellaneous Expenditures	320	2,000	1			100%	625.00%	0.31%	0.00%	0.00%
MIS Direct Charges			3,491		0	100%				
Overhead Expenditure Total	**779,035**	**764,060**	**714,257**	**907,240**	**973,060**	**100%**	**98.08%**	**91.68%**	**116.46%**	**124.91%**

Note: * Includes Income Maintenance Utilites for comparison purpose

REVIEW OF 2012 GOALS

1. **Protective Payee**

Approximately 189 clients were on the protective payee system. We had 238 Social Security reviews. Bank reconciliations were being completed on a monthly basis. We had 853 contacts with clients, Care WI, or guardians to review budgets. We had 1,162 contacts with Clients/Care WI workers or guardians for problem solving and resolution. Additionally, with the help of a part time volunteer, this area processed an average of 1260 checks per month for client bills. We had a range of 495-1258 calls per month.

2. **Children Long Term Services (CLTS Waivers)**

This was the first full year making payments for providers through WPS. We worked with providers to resolve billing and payment issues. MIS staff developed a system for authorizing payments, which has been effective.

3. **Employee Reimbursement for Travel/Training Expenditures**

We implemented electronic entry for all travel and training expenses and reimbursements. This system was programmed by MIS and has saved staff time.

4. **Automate payroll time sheets for Economic Support staff**

This project was implemented with assistance from MIS. It has saved staff time and reduces the possibility of data entry error. This project also automated the tracking of job functions for allocation of work time to the state.

5. **Implement continuous quality improvement NIATx projects**

a) Completed a process to ensure that clients are informed about their responsibility for paying for the inpatient services at the time of admission. A system is in place for billing clients on a monthly basis for Inpatient, Lueder House and Detox services.

b) Systems are in place to review notes for all billing areas prior to billing insurance. The process is done on a monthly basis to ensure that Medicaid/Medicare requirements are met.

c) Various spreadsheets were developed to monitor time lines of activities to ensure compliance of deadlines.

d) Modifications were made in the billing system to put additional edits in to track compliance of paperwork requirements prior to billing services.

6. **Mandated switch from State Human Services Reporting System HSRS to Program Participation System PPS**

The transferring of data from State Human Services Reporting system (HSRS) to the new State Program Participation System (PPS) system was completed. This required working with MIS to modify the client master file to add additional information and to pull client information to transfer to the state. All information will now be keyed in to the client master file once and uploaded into the state system on a monthly basis.

7. **Develop and implement financial reporting for the Economic support Division to the consortium**

The Income Maintenance program changed to a 7 county consortium contract versus contracting directly with the state. We worked with the fiscal staff from the 7 county consortium to develop a process for reporting monthly expenditures to meet deadlines. This process has been working effectively.

8. **Work with managers/supervisors to include performance outcomes in the 2013 provider contracts**
Contracts have been updated to include performance outcomes in the 2013 contracts.

9. **Comprehensive Billing System**
Fiscal staff worked with the MIS Department to implement a comprehensive billing system and develop a system for electronic records.

MIS, Fiscal staff and Program Managers are working on the development of an electronic records system. Two elements must be completed prior to launching. Due to the sensitivity of client information, only appropriate staff can have access. Additionally, a release of information is required for some teams to share information. We expect completion by mid 2013.

2013 GOALS

1. Assist in the implementation of electronic records across the agency.
2. Timely billing of services within 90 days of date of service.
3. Documentation of billing systems
4. Documentation of contracting process
5. Cross training for job functions and state reporting.
6. Homestead Tax Credit – work with VITA program to provide this service to clients needing assistance in the protective payee program.

* * *

MAINTENANCE

~Ensuring that all functions of the buildings and grounds are in safe, working order~

REVIEW OF UTILITY COSTS FOR
Health/Human, Workforce/UW Extension, Hillside and Lueder House Buildings

Over the last four years, we have carefully reviewed utility costs. All buildings have been used more with increased client visits and meetings. When looking at the graph, November and December 2012 experienced more degree heating days than 2011. Overall the usages are not changing as much as last year with the exception of July, which was a very warm month.

Maintenance continues to add energy up-grades wherever possible. One example is the new lighting at Lueder House/CSP. We upgraded the exterior lighting from incandescent to energy efficient LED. Additionally, we added a parking lot pole with LED fixtures. This addition improves both the lighting at night and adds a measure of security. These upgrades were done in October and November and the electric graph reflects the lower usage.

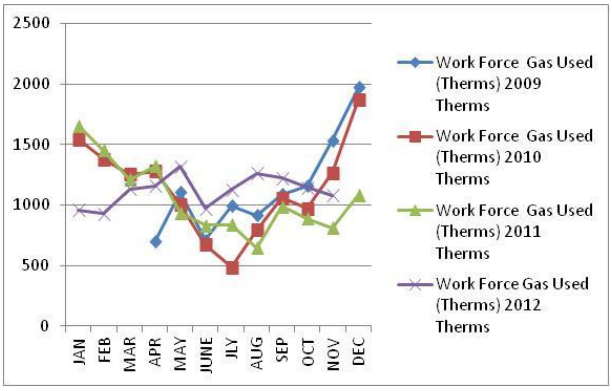
We plan to budget for upgrading the parking lot lights from High Pressure Sodium to LED at all of the buildings. The initial cost will be in the $30,000 range to accomplish this. The savings will be realized over time from both lower electric costs and staff time to replace burned out bulbs as LED has a much longer life span.

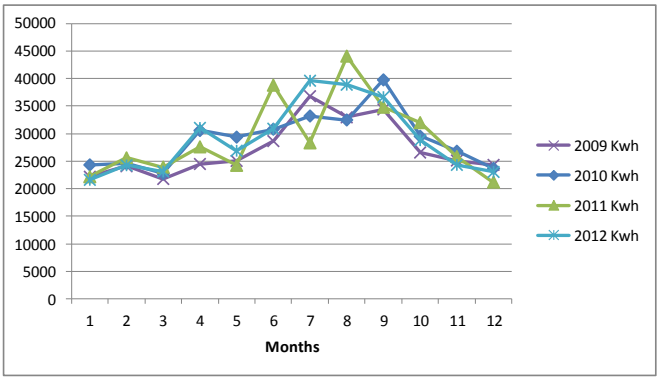
WORKFORCE DEVELOPMENT BUILDING

This building has experienced a dramatic increase of use due to the economy as well as the harsher winter and spring.

Work Force Gas Used (Therms)				
Month	2009 Therms	2010 Therms	2011 Therms	2012 Therms
JAN		1,542	1,657	958
FEB		1,378	1,454	928
MAR		1,252	1,209	1134
APR	699	1,279	1,322	1158
MAY	1,104	1,008	936	1319
JUNE	713	671	833	972
JLY	992	484	839	1127
AUG	915	794	646	1262
SEP	1,088	1,060	989	1224
OCT	1,158	973	889	1146
NOV	1,535	1,266	811	1080
DEC	1,974	1,874	1,086	1278

	Electric Usage - Workforce Development Building									
	2003 Kwh	2004 Kwh	2005 Kwh	2006 Kwh	2007 Kwh	2008 Kwh	2009 Kwh	2010 Kwh	2011 Kwh	2012 Kwh
J	14560	16640	16000	17360	21200	22880	22160	24320	22160	21600
F	13760	16240	17680	20640	22960	24640	24080	24560	25600	24240
M	14400	16400	16320	18400	20240	16640	21760	22720	23920	23120.00
A	16960	19680	21520	24480	20960	20560	24480	30560	27600	31040.00
M	16480	19040	20320	23680	24080	24320	25040	29360	24240	26880.00
J	18400	25040	24240	25920	29200	30720	28640	30800	38800	30880.00
J	23520	23120	30160	32720	28080	25520	36800	33200	28320	39600.00
A	24880	26160	31920	31360	29840	27520	32960	32480	44080	38880.00
S	30400	25840	29760	32480	30480	29760	34400	39760	34800	36640.00
O	14400	22480	24320	23120	28000	27920	26560	29520	32000	28800.00
N	17920	20560	22720	20160	27360	26560	25120	26800	25840	24320.00
D	17040	20400	22240	23360	21840	24720	24320	23680	21200	23040.00



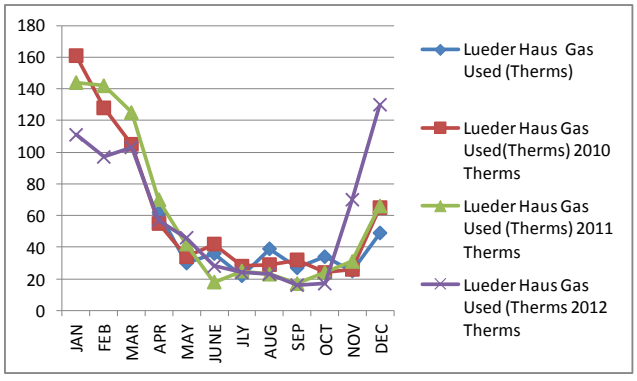


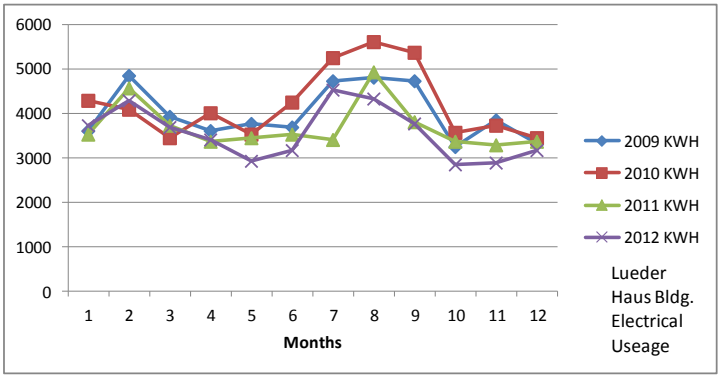
LUEDER HOUSE

The Lueder House is our crisis stabilization facility. In the last several years it has been near maximum capacity each day. Natural gas usage was up in 2012, but electric continued to decrease due to lighting up-grades.

Lueder Haus Gas Used (Therms)				
Month	2009 Therms	2010 Therms	2011 Therms	2012 Therms
JAN		161	144	111
FEB		128	142	97
MAR		105	125	103
APR	62	55	70	57
MAY	30	34	42	46
JUNE	36	42	18	28
JLY	22	28	25	24
AUG	39	29	23	23
SEP	27	32	17	16
OCT	34	24	24	17
NOV	25	26	31	70
DEC	49	65	66	130

Electric Usage - Lueder Haus Bldg										
	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH	2012 KWH
J	4000	4080	3920	4080	4160	4400	3600	4280	3520	3720
F	4640	4560	4960	3560	5520	5320	4840	4080	4560	4280
M	4040	3560	3360	4200	4120	3360	3920	3440	3720	3680
A	3640	4120	3840	4040	3680	3720	3600	4000	3360	3400
M	3400	3280	3360	4040	3800	3440	3760	3520	3440	2920
J	3480	3680	4320	4320	5120	4400	3680	4240	3520	3160
J	4360	4920	5800	5040	4760	4560	4720	5240	3400	4520
A	4840	4520	5960	5640	5360	4800	4800	5600	4920	4320
S	4480	4760	5160	5000	5640	4880	4720	5360	3800	3760
O	3720	3880	3960	3960	4520	3680	3240	3560	3360	2840
N	3240	3760	3040	3160	3960	3440	3840	3720	3280	2880
D	3480	4000	4280	4480	4080	4440	3320	3440	3360	3160



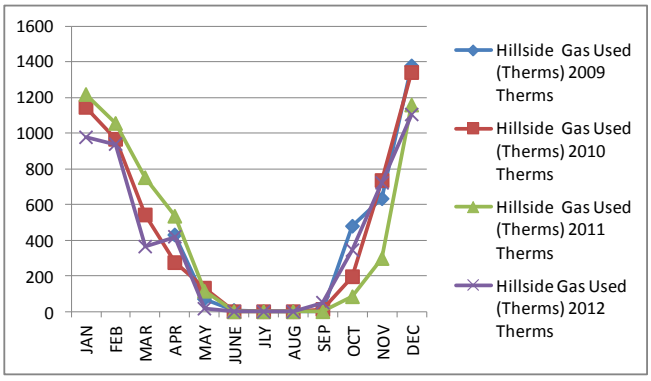


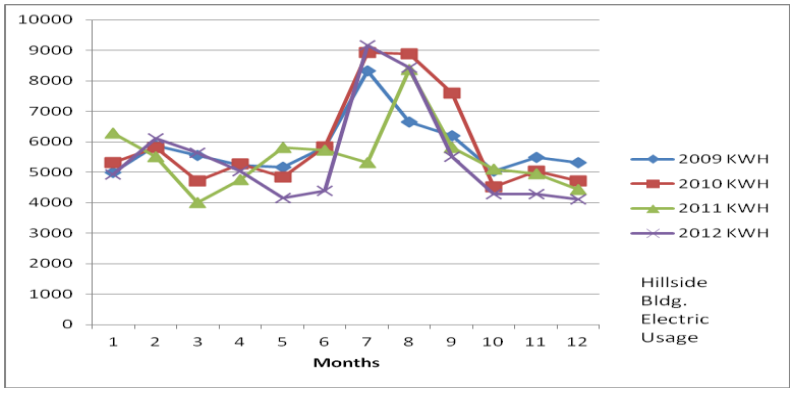
HILLSIDE

Hillside is a building from the 1920's, where staff are now located. Natural gas was up in October and November but declined in December. Electric use was on the decrease at the end of 2012 as we continued to add more efficient lighting in this building.

Hillside Gas Used (Therms)				
Month	2009 Therms	2010 Therms	2011 Therms	2012 Therms
JAN		1145	1217	977
FEB		966	1055	939
MAR		542	751	365
APR	430	275	535	420
MAY	71	132	115	17
JUNE	7	0	0	0
JLY	0	0	0	0
AUG	0	0	0	0
SEP	0	13	0	51
OCT	479	196	84	345
NOV	633	735	298	722
DEC	1377	1340	1158	1105

	Electric Usage - Hillside Bldg									
	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH	2012 KWH
J	6640	6080	5440	6320	6120	6640	5000	5320	6280	4920
F	6520	6720	7320	5480	7240	8320	5880	5800	5520	6120
M	5880	5840	6120	6400	5760	5440	5560	4720	4000	5640
A	5960	6680	7280	5680	5280	10480	5240	5280	4760	5040
M	6040	6240	6520	4960	5800	1920	5160	4840	5800	4160
J	5000	5480	7000	6000	7960	7320	5840	5840	5720	4400
J	7680	6840	9680	7520	8640	7120	8320	8920	5320	9160
A	8680	7040	10120	9160	9360	8000	6640	8880	8360	8440
S	8720	6360	7720	7360	8760	7240	6200	7600	5800	5520
O	6320	6680	5960	5800	6560	5880	5040	4520	5100	4280
N	5880	6440	5640	5240	6920	6480	5480	5040	4960	4280
D	5840	6520	6640	6280	6480	6360	5320	4720	4440	4120



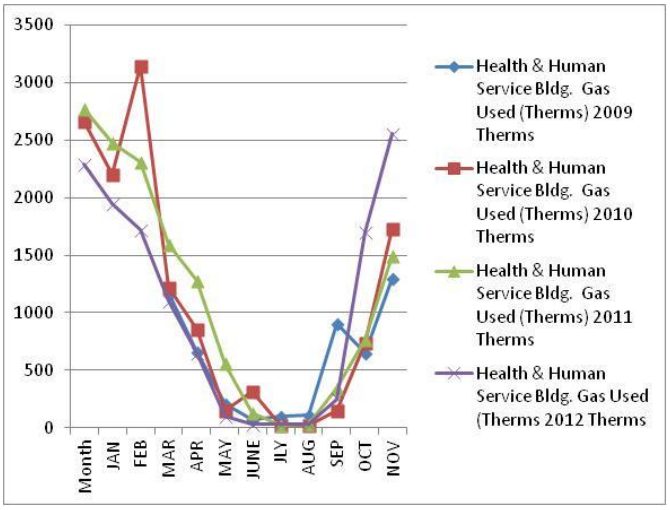


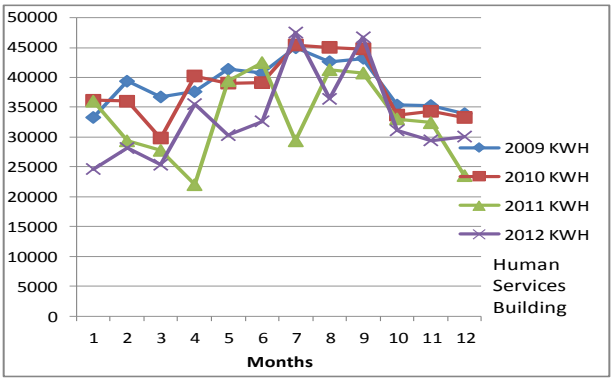
HEALTH & HUMAN SERVICES

This is the main building with the offices for Administration, Aging & Disability Resource Center and the Child & Family Divisions. Building use is up for all facilities including Health/Human Building. One area of increased use is the Free Clinic; this is now operated five days per week. We ended the year with an increase in energy consumption.

Health & Human Service Bldg. Gas Used (Therms)				
Month	2009 Therms	2010 Therms	2011 Therms	2012 Therms
JAN		2663	2772	2287
FEB		2203	2476	1948
MAR		3141	2311	1716
APR	1170	1218	1592	1099
MAY	659	854	1283	651
JUNE	210	153	558	105
JLY	72	319	134	37
AUG	102	27	27	31
SEP	109	27	29	30
OCT	903	153	350	254
NOV	649	742	772	1699
DEC	1298	1730	1493	2550

Electric Usage - Human Services Building										
	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH	2012 KWH
J	39440	41760	40560	43280	43120	41360	33280	36160	36000	24640
F	47680	42960	46240	38720	52160	48080	39360	36000	29360	28160
M	28560	36720	38880	46160	42640	32080	36720	29840	27760	25360
A	39440	44560	44960	42720	40800	38480	37600	40240	22000	35520
M	39680	39280	39040	45200	45040	37200	41360	39040	39440	30320
J	42320	40800	45760	42400	52320	51680	40720	39120	42480	32640
J	50880	52960	50080	49040	48480	41440	44960	45440	29360	47520
A	51760	49600	51920	55840	51200	43440	42640	45040	41280	36400
S	48560	48560	47200	49360	53760	47040	43200	44800	40720	46720
O	45920	40560	41840	44080	43840	43680	35360	33680	33040	31120
N	38080	40480	37680	38080	42960	47920	35280	34320	32400	29440
D	38560	43600	43920	43840	40800	42960	33920	33280	23520	30080





REVIEW OF 2012 GOALS

1. Continued to upgrade lighting in the Hillside Building and Lueder House. The upgrades ranged from High Performance T8 to LED fixtures; the results are lower energy usage with improved lighting quality.

2. Flooring replacement is an ongoing project and we plan to replace carpet and VCT in Lueder House and CSP from a budget addition of $10,000.

3. Installed an emergency notification system so all staff can be notified simultaneously in an emergency, and to follow the established protocols.

2013 GOALS

1. Request to budget money in 2014 to replace the Hillside roof. The age of this roof is unknown and has not been replaced or repaired for at least 28 years.
2. Replace all windows in Hillside with energy efficient thermopane glass to improve on heating and cooling costs.
3. Install scanner door locks at all points of entry
4. Replace boilers in Health and Human Services building.
5. Remodel three work regions for Human Service staff

* * *

SUPPORT STAFF

~Assisting staff and customers to ensure a seamless delivery of services~

The Support Staff is a vital team within the department working diligently behind the scenes. We help external customers by making appointments and providing information. It is imperative that our team is knowledgeable about all county resources so that we can direct customers to the proper agencies, such as local food pantries or PADA. We also process requests for the release of medical records which requires staff to understand the many statutes covered under HIPAA, Mental Health, AODA, and Child Welfare.

We assist internal customers by maintaining charts and client paperwork, typing and processing reports, making appointments, and helping with special projects. Having excellent communication skills are critical for our staff due to the constant changes throughout any given day. All staff are also crossed trained and able to backup each other to ensure a seamless delivery of services to both internal and external customers.

REVIEW OF 2012 GOALS

1. Developed an informational PowerPoint presentation to play on the lobby TV. This will help educate visitors about the many programs and policies that Human Services has as well as what other county departments have.
2. Completed a NIATx Quality Improvement initiative to access interpreters. This will provide Department continuity when contacting an interpreter, provide better customer service, ensure that the interpreter understands their performance requirements and meets Medicaid requirements, and ensure a better internal billing process.

2013 GOALS

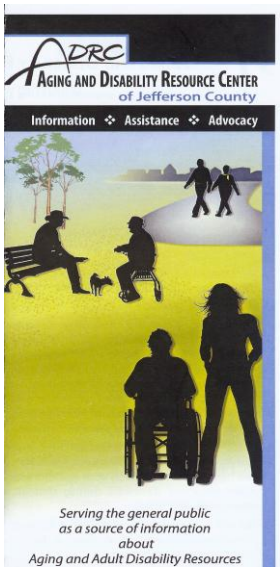
1. Purchase a scanner to reduce the work to prepare releases
2. Expand the closed files room. Work towards eliminating filing duplicate or unnecessary papers.
3. Complete the Civil Rights Compliance Plan
4. Create a list of all forms and save to the Department database

* * *

AGING & DISABILITY RESOURCE DIVISION

Providing services seamlessly to the elderly and persons with disabilities

The Aging & Disability Resources Division of Jefferson County Human Services encompasses many programs and funding streams. The division has two distinct units, which provide services seamlessly to the elderly and persons with disabilities.



The Aging & Disability Resource Center, or ADRC, is 100% funded by state general purpose revenue and federal Medicaid dollars. Federal dollars are earned based on staff activities. The ADRC is required to earn 25% of its support from the federal government in order to meet its budget. The ADRC has consistently earned 40% since opening in 2008 and one new staff member was hired in 2012.

The Aging Programs are funded with federal and state dollars, county tax levy and private donations. Federal funding comes from the Older American's Act, or OAA. The mission of the OAA is to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for the most vulnerable older adults.

Counties are required to use funding in several different categories, including advocacy, access, benefits counseling, caregiver support, nutrition services and evidenced based prevention programming.

AGING & DISABILITY RESOURCE DIVISION TEAMS

Aging & Disability Resource Center

Adult Protective Services

Elder Benefit Specialist

Senior Dining Program

Transportation

AGING & DISABILITY RESOURCE CENTER

~Providing information and assistance or services for older adults and persons with physical or developmental disabilities and their families~

Aging and Disability Resource Centers (ADRC's) offer the general public a single entry point of access for information and assistance on issues affecting older people and people with disabilities, regardless of their income. Individuals, family members, friends or professionals working with issues related to aging, physical disabilities, or developmental disabilities can receive information specifically tailored to each person's situation. Information and assistance services are about providing personalized help in finding and connecting a customer to services that match his or her needs. Staff at the ADRC assist people to determine their need and consider what services and programs are available in their area to meet their specific needs. In 2012, the Aging and Disability Resource Specialists had 5, 271 contacts with consumers.

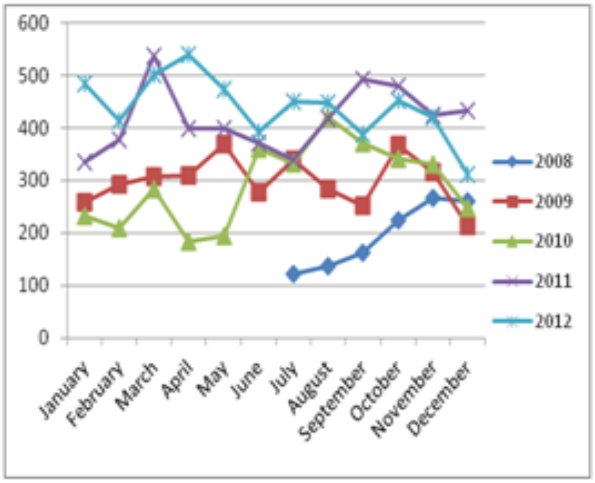
2012 Highlights

◊ The Cap on Publicly Funded Long Term Care Programs was lifted. There is no longer a wait list for Family Care, Partnership or IRIS funding for adults with long term care needs in Jefferson County!

◊ Aging & Disability Resource Specialists were trained to promote the Living Well with Chronic Conditions educational series.

◊ Grant awarded for one year to fund a Dementia Care Specialist in the ADRC. ADRC Staff are trained to provide Memory Assessments and Screening.

◊ There was a monetary impact of $3,712,442 for elder and disabled Jefferson County residents with the help of our benefit specialists.

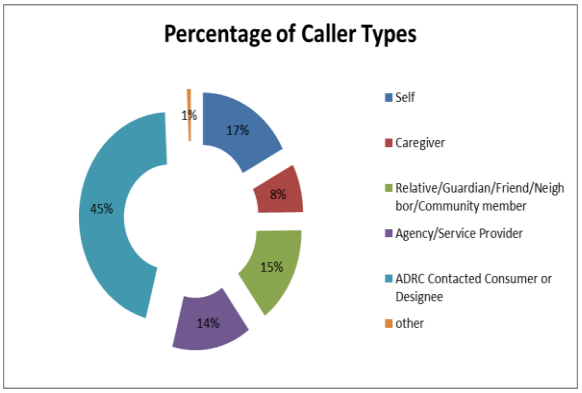


2008	2009	2010	2011	2012
1171	3585	3509	5126	5271

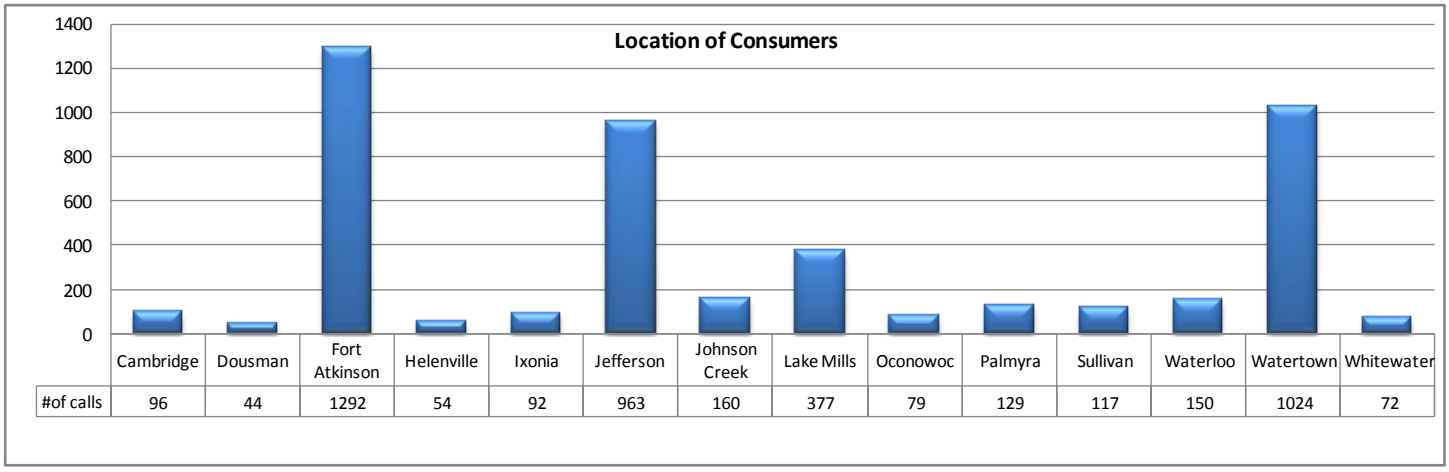
Record of Contacts 2008 – 2012

Contacts July 2008 thru December 2012

In 2012, the ADRC recorded 5,271 contacts in SAMS IR, which is the database used for collecting data on all ADRC activities. A contact represents individual one-on-one interactions that have occurred between ADRC staff and a person who contacts the ADRC. A contact may occur in person, including home visits and walk-ins, over the telephone, via email or thru other written correspondence. An individual may contact the ADRC multiple times; each interaction is counted as a contact. Included in the number of contacts are follow-up calls made by ADRC staff members to ensure that customers have received any mailed information and to check in to see if they need any other assistance. According to the Wisconsin Department of Health Services 2011 Summary Report, follow-up contacts have a strong impact on every measure of customer satisfaction.



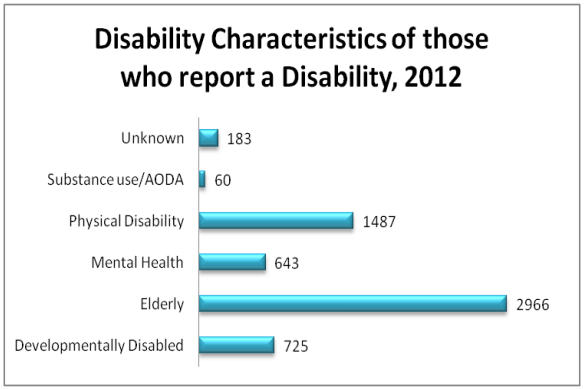
Other interesting statistical information that is tracked within our database allows us to paint a picture as to who is calling the ADRC, what topics they are primarily interested in and which communities are consumers calling from. Our statistics show that 63% (3,346 contacts) of known contacts were on behalf people 60+; 35% (1860 contacts) were made on behalf of people between the ages of 18-59 and less than 2% (65 contacts) were regarding children under the age of 18. The three primary topics that people contacted the ADRC for was information related to public benefits 65% (3,450 contacts), Medicaid 48% (2,534 contacts) and Assisted Living Options 14% (782 contacts.)



	Cambridge	Dousman	Fort Atkinson	Helenville	Ixonia	Jefferson	Johnson Creek	Lake Mills	Oconowoc	Palmyra	Sullivan	Waterloo	Watertown	Whitewater
#of calls	96	44	1292	54	92	963	160	377	79	129	117	150	1024	72

ADRC's serve the elderly and adults with physical or developmental disabilities, regardless of their income. ADRC services are available to individuals who need assistance, their families, friends, caregivers, guardians and to youth transitioning into adult programs. Information, referral and benefits counseling is available to adults with mental illness and/or substance use disorders who also have long term care needs. The majority of ADRC customers are caring for or living with disabilities. Customers are not required to share this information; of those customers who shared, the following table shows the distribution of disability characteristics. Please note that more than one condition may be identified for an individual.

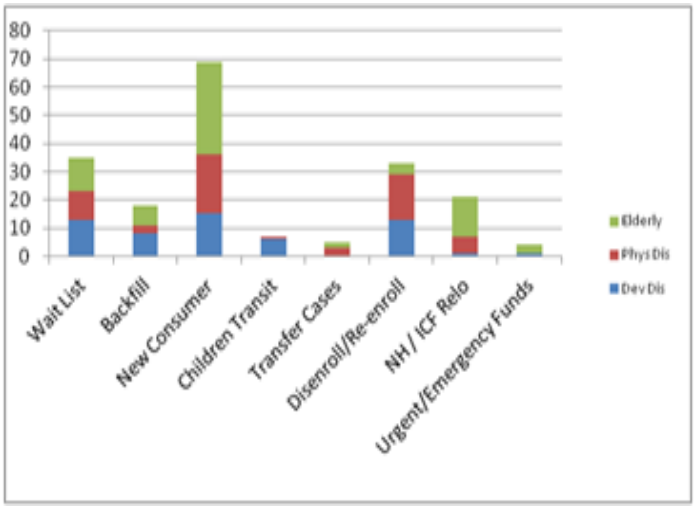
ADRC's are also places where people are offered option's counseling to maximize their personal resources and to access Wisconsin's publicly funded long term care programs, including Family Care and Partnership and IRIS. Staff at the ADRC provide one-on-one consultation to help people identify and think through the pros and cons of the various options in light of their situation, values, resources and preferences. Staff provide information that is useful in extending personal funds when privately paying for services. When people are no longer able to pay for needed services, ADRC's are the single entry point for long term care programs that can support them in their own home and often avoid institutional placement.



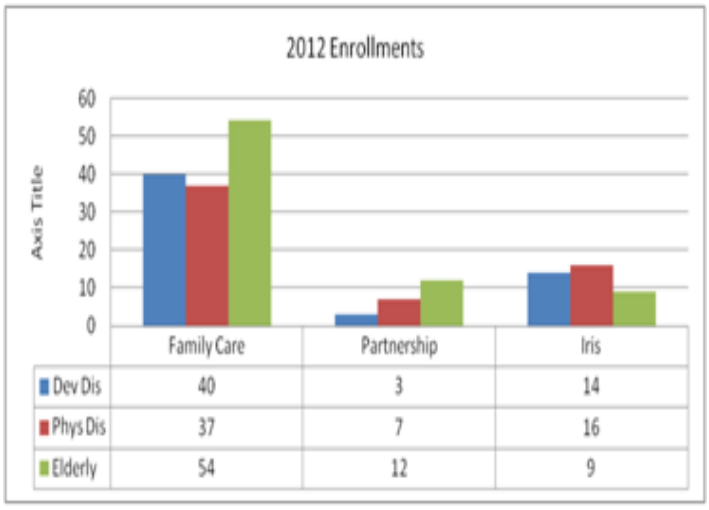
Enrollment Counseling

In 2012, the ADRC completed 192 enrollments into Family Care, Partnership or IRIS. The enrollment cap was lifted on April 3, 2012 and since then we have enrolled more new consumers in 2012 then we had on our wait list at the beginning of the year. Per the State of Wisconsin's monthly snapshot of enrollment data (dated 1/1/2013) in Jefferson County, there are 770 members enrolled in the Family Care Program, 87 enrollees into the Partnership Program and 83 participants enrolled in the IRIS program.

Consumer Status of Enrollment



Long Term Care Program Enrollments



	Family Care	Partnership	Iris
Dev Dis	40	3	14
Phys Dis	37	7	16
Elderly	54	12	9

Community Relocations from Nursing Homes: People living in nursing homes and other institutions do not always know about community services, support and housing options. The ADRC Staff meet with consumers through a referral from hospital discharge planners and/or nursing home admission social workers. In 2012, twenty consumers were relocated from a nursing home setting and one consumer from an Intermediate Care Facility for people with Mental Retardation (ICF-MR).

REVIEW OF 2012 GOALS

1. The ADRC met its goal to work with DHS on the Long Term Care Sustainability Plan.

2. The goal to train and certify I & A Staff in an evidenced based prevention program called *Living Well with Chronic Conditions* was also met. Program implementation was not started until 2013, due to work schedules and the cap being lifted.

3. The ADRC worked on three Aiming for Excellence, or NIATx projects in 2012:
   a) ADRC, Where are you?
   b) Introduce and increase new customers to the ADRC via its Website; and
   c) Options counseling to increase the customer's ability to be healthy at home.

4. Improving brochures and handouts is an ongoing goal. The ADRC worked with the Jefferson County Transition Network to create a Roadmap for youths and their families. A new Youth Transition Resource brochure and folder was also created for youth and their families and it is provided to them when staff meet to discuss options.

2013 GOALS

In 2012, the ADRC was featured in "To Your Health", a quarterly supplement to the Daily Jefferson County Union and "Family & Friends" a quarterly supplement to the Watertown Daily Times. We have increased our marketing tactics via ads in newspapers and quarterly supplements. The ADRC sends out Customer Satisfaction surveys and one noticeable attribute from the surveys is asked "How did you hear about the ADRC?" Most consumers responded that they were referred by someone else; a few noted phone book, internet, and newspaper articles. If consumers are be referred by word of mouth, so to speak, then the ADRC needs to become more involved in community events so we are more visible to people to spread the word.

1. Continue to promote the ADRC and raise awareness of programs and issues relating to aging and disability.
    a) Increase outreach efforts in our communities by being visible at food pantries, Farmer's markets, and other community fairs.
    b) Increase staff presentations at community organizations and support groups.
    c) Utilize the Aiming for Excellence quality improvement process to increase new ADRC customers thru advertising/marketing venues.

2. Increase promoting health and wellness via educational programs such as Living Well with Chronic Conditions, fall prevention, and providing memory assessments and screening.
    - The ADRC will hold two Living Well Classes in 2013.

3. During this past year, Aging and Disability Resource Specialists were trained on providing memory assessments and screening. In 2012, 14 memory screens were provided. Our goal would be to increase our number of assessments by 50% during the year 2013.

4. In 2013, the Disability Benefit Specialist plans to educate consumers in an effort to make them aware of their Medicare Benefit choices. It is proposed that the program will use two initiatives to address the issue. First, the program will perform more outreach in the county. Secondly, the program will complete a mass mailing before the Medicare Open Enrollment period.

* * *

AGING PROGRAMS

~Providing services for the elderly and persons with disabilities of Jefferson County~

Advocacy

The Older American's Act (OAA) is the foundation of the Aging Network and its central tenet is advocacy. The OAA provides the framework under which the ADRC Advisory Committee operates and involves committee members in advocacy activities, including:

1. Assisting in the development of better public policy;
2. Ensuring that the Aging & Disability Resource Division is accountable to citizens;
3. Giving a voice to (misrepresented or underrepresented) citizen interests;
4. Mobilizing citizens to participate in the public policy process; and

5. Supporting the development of a culture of tolerance, equality and acceptance of people with disabilities and the elderly.

REVIEW OF 2012 GOALS

1. In 2012, older adults were involved in an Environmental Scan during the 2013-2015 Aging Unit Planning Process. ADRC Advisory Committee members were active in their local communities engaging people in the planning process. In addition, ADRC management staff spoke to various groups about the proposed plan.

2013 GOALS

1. Hold Advocacy Trainings quarterly

Senior Dining Program

Fellowship, Food Fun

Good nutrition plays a crucial role in keeping older people healthy and functioning. Unfortunately, far too many older Americans aren't eating well. They may have a hard time getting groceries due to loss of transportation or due to functional limitations. Many older adults cannot afford to buy the kind of foods that are most healthful for them and for many others it's not a question of eating well but of eating at all. Millions of older Americans are hungry or worried about where their next meal is coming from.

One National Survey found that Senior Dining Participants are: significantly poorer than the general US population, they are primarily women living alone, are on average 76 years old and most likely to be a minority. The survey also found that many participants were hospitalized or in a nursing home in the past year and have 2-3 chronic conditions, 3 or more functional impairments and are at moderate to high nutrition risk.

Allocations of state money going to federally funded Older American's Act programs, which includes Senior Dining, are based on a county's percentage of people who are age 60 and low-income. At the time of Census 2000, the number of people age 60+ with income below 125% of poverty was 1,070. This was 1.074% of the state's total older low-income population. At the time of the American Community Survey data which is what is being used for 2013, Jefferson's older low-income population had grown to 1,555, which was 1.292% of the state's total older low-income population. This shift in population change resulted in nearly a 17% increase in funding for Senior Dining.

The Senior Dining Program served 634 unduplicated individuals for a total of 28,283 meals in 2012. The congregate sites served 12,175 meals, and 16,708 home deliveries were made. Seventeen percent of participants were provided nutrition counseling services.

REVIEW OF 2012 GOALS

During the time that meals were served by ***Hoffman House***, program staff promoted "My Plate" which promotes the 2010 Dietary Guidelines for American's as published by the USDA. The program

met the goal to see an increase in satisfaction with the meals via participants; however, the number of participant's who were not satisfied led to the dramatic decline in participation. When all was said and done, participants "voted with their feet" and the outcome was resounding.

2013 GOALS

1. Nutrition Program staff continually engage in discussions with GWAAR (Greater WI Agency on Aging Resources) and the Department of Health Services about "modernizing" the Senior Dining Program to ensure that it is meeting people's wants and needs.

2. In January 2013, the Nutrition Program Coordinator and Home Delivered Meal Assessor were trained to facilitate an evidenced based prevention program called: ***Healthy Eating for Successful Living Among Older Adults.*** The overall goal of Healthy Eating is to increase self-efficacy and general well being by improving participants' knowledge of nutritional choices that focus on heart and bone healthy foods as well as supportive physical activities. Goal setting, problem solving and self-monitoring are used to optimize individual behavior change.

3. The goal is to offer this program at least twice in 2013.

Transportation Services

Jefferson County provides transportation services to the elderly and persons with disabilities via volunteer drivers and one paid van driver. Services are funded via the s85.21 Specialized Transportation Program, Family Care, Partnership, county tax levy, and passenger co-payments. Persons seeking access to medical care are given priority services, as well as those needing help in meeting their nutritional needs.

Jefferson County provides the following services:

1. Elderly Services Van: Provides transportation on a fixed route basis to elderly and disabled individuals for grocery and other shopping trips. In 2012, 3,121 one-way trips were provided. Passengers are asked for a $1.00 co-payment per one-way trip.

2. Taxi Program Subsidy: Provides a user-side subsidy for taxi services provided to elderly who use the taxi in order to attend a Senior Dining Program in Fort Atkinson, Jefferson and Lake Mills. In 2012, 311 one-way trips were subsidized at .75 per trip. This is a significant decrease of nearly 38% from 2011.

3. Driver-Escort Program (volunteer drivers): Provides door-to-door transportation to elderly and disabled individuals for medical appointments when they have no other transportation options. In 2012, volunteer drivers provided 3,591 one-way rides. Passengers are asked for a $1.00 co-payment per in-county trip and a $5.00 co-payment per out-of-county trip.

REVIEW OF 2012 GOALS

1. The goal to collaborate with the Community Action Coalition on a grant application was met; however, the grant application was not awarded funding. An unexpected grant opportunity was announced in the fall of 2012 by Brown Cab Company after they were selected to receive funds from the Community

Transportation Association of America (CTAA) for an intensive study of service needs and gaps. The announcement is very timely since county provided van service is likely to end by 2014. The idea behind the cab companies grant application is to explore ways to expand taxi service on a county-wide basis and this proves to be a very worthwhile study. Older adults have significant transportation needs, yet they are like their younger counterparts in terms of driving themselves, so that they can go when and where they want to go according to their own schedules.

2. The goal to increase van ridership was met, after the driver's schedule was changed to increase availability for rides generally provided under the volunteer driver program.

3. Reaching isolated seniors is an ongoing goal in all program areas, and a variety of activities were undertaken to reach out to isolated seniors with transportation needs. Some highlights include the following: 1) running a weekly display ad in a local newspaper for several months; contacting each communities Chamber of Commerce to ask for their help in informing members about our services; putting transportation notices in mailboxes in a mobile home park in one of our most rural communities and the transportation team went on the WFAW Morning Magazine radio talk show to promote our services. None of these activities resulted in any measurable change in ridership.

2013 GOALS

1. Work with the CTAA Transportation Surveyors to identify transportation providers, needs, barriers and gaps in current services.
    a) Host a coordinated transportation committee meeting to review current county provided transportation services;
    b) Keep the ADRC Advisory Committee and Human Services Board appraised of all planning efforts;
    c) Explore various options, including:
        - Hiring part-time drivers,
        - Subsidizing taxi service at a higher level should it expand on a county-wide basis,
        - Purchasing taxi tickets in lieu of providing rides,
        - Offering transportation vouchers.

Benefit Specialists

During the 12 month period which ended Sept. 30, 2012, the Jefferson County Elder Benefit Specialist program served 789 unduplicated clients and reported 1,777 contacts, resulting in $1,911,434 in financial monetary impact.

REVIEW OF 2012 GOALS

1. The EBS program had 49 contacts with 13 Hispanic clients in fiscal year 2012 and will continue to strive to increase visibility of the program within the Hispanic community.

2. Another goal in 2012 was the implementation of a new volunteer program, which was supported with a $3000 national grant from the "Medicare Rights Center". The EBS program recruited five retirees committed to the SOS (Seniors Out Speaking) project. The SOS volunteers were provided monthly training and materials to present monthly "Medicare Minutes" to peers in Lake Mills, Waterloo, and Watertown for one year. In order to sustain this program, the EBS new goal is to form an SOS

Leadership team (from the original volunteer base) to assist with recruitment and mentoring of new SOS volunteers in the remaining communities in Jefferson County.

3. The bi-monthly ABCs of Medicare "classes" have been well attended, and are included on the EBS link of the ADRC website. The popular collaborative workshop "Puzzled About Medicare" had 83 members in the audience, thus will be repeated again in September 2013;

2013 GOALS

1. Incorporate an SOS Leadership team (volunteer based) to recruit and mentor new SOS volunteers in each community with at least 1 presentation per month.

2. Increase Jefferson County Senior FoodShare Participants by 20%

3. Increase Hispanic caseload by 10%

Disability Benefit Specialist Program

In 2012, the Disability Benefit Specialist Program served 228 consumers with disabilities aged 18 to 59 years. For those consumers, 377 cases were opened to address a wide variety of issues. The most common issues being: SSDI/SSI Eligibility, Post Entitlement issues with SSDI/SSI benefits, Health Insurance and Food Share. During the year, 166 applications for benefits were completed. The monetary impact to Jefferson County from successfully completed cases by the Disability Benefit Specialist was $1,738,739.00.

In 2012, a targeted effort was made to educate consumers about their current and potential benefits. This effort allowed for an increase in Income Support cases rising from the 2011 number of 127 cases to 163 cases in 2012.

Family Caregiver Support Programs

The department currently coordinates caregiver services and benefits under the following two programs: 1) National Family Caregiver Support Program; and 2) Alzheimer's Family Caregiver Support Program. These programs are intended to provide caregivers with information about available services; assistance in gaining access to services; individual counseling, support groups and training; respite care to give them a break from providing care and supplemental services to compliment care.

In 2012, twenty-seven caregivers were provided funding under the National Family Caregiver Support Program which covered 1,152 hours of service. Often times caregivers work with private providers, i.e. friends and neighbors, whom they trust, at a reduced rate, so they are able to stretch their $500 budget. The average cost of hourly respite services was $12.28. This is approximately 48% less than the cost of agency provided services.

The Department of Health Services awarded Jefferson County with grant funds in order to develop a Dementia Care Specialist Pilot Project. The grant period runs from 10/1/2012-10/1/2013. The main focus of the project is to help caregivers continue to care for their loved ones in order to delay or avert placement into nursing homes.

REVIEW OF 2012 GOALS

The goals established in 2012 were met.

2013 GOALS

1. Facilitate a Dementia summit

2. Collaborate with other professional organizations to offer a variety of educational programs for caregivers

3. Develop a volunteer program, called LEEPS, *Language Enriched Educational Program, which is an ex*ercise & social outing program for people with memory loss

4. Facilitate Memory Care Connections Programming in order to help caregivers develop a plan for support relying on friends, family and others that they can count on to help.

Adult Protective Services (APS) & Abuse/Neglect of Vulnerable Adults & Elders

The APS unit is responsible for ensuring that the health and safety needs of the elderly or individuals with disabilities are met, especially when they are in situations where there is cognitive impairment and substantial risk is evident. Several different statutes cover the counties responsibilities in responding to these situations, and the Human Services Department is the designated "lead agency" for receiving and responding to allegations of abuse or neglect.

In 2012, a lot of work was done to simplify the procedures and billing processes as they relate to Corporate Guardians. There are approximately 95 individuals with corporate guardians and the department paid for those services on a monthly basis. The guardian then reimbursed the county from each of the ward's accounts who were found to have sufficient funds to do so. After the changes were implemented on 2/1/13, the department is now billed for 14 individuals.

In 2012, this unit completed the following:

- 189 Annual Review of Protective Placements or WATTS reviews
- 71 Elder Abuse Investigations (60+)
    - 39.4% Self-Neglect
    - 21.1% Financial Exploitation
    - 15.5% Neglect by Others
- 29 Vulnerable Adult Investigations (18-59 years)
    - 27.6% Physical Abuse
    - 17.2% Sexual Abuse
    - 6.9% Emotional Abuse
- 69 Petitions for Guardianship, 53% increase from 2011

REVIEW OF 2012 GOALS

1. The goal to work with the Probate Office to develop practices that ensure that guardians understand their reporting responsibilities to avoid unnecessary court hearings was met.

2. The goal to work with *Your Friends in Action* to recruit volunteers who are committed to helping vulnerable adults who are at the high risk for abuse/neglect was not met due to staff turnover and significant changes to that organizations programs. This goal will be carried forward to 2013.

2013 GOALS

1. Host a Volunteer Guardian Recruitment training/event

2. *Your Friends in Action* volunteers work extensively with vulnerable adults who are at the high risk for abuse/neglect. Provide training on spotting the Red Flags of abuse or neglect.

* * *

BEHAVIORAL HEALTH DIVISION

Assessing participants for strengths and needs; and integrating the principles of hope and empowerment

Jefferson County utilizes a fully integrated, county staffed, behavioral health service delivery system. County provided programs include the Mental Health and AODA outpatient clinic, Comprehensive Community Services Program, (CCS), Community Support Program, (CSP), Crisis/Emergency Mental Health Services, and Coordinated Service Teams, CST/Wraparound). Additionally, we operate the Lueder House, an on-site, adult licensed eight bed group home, which serves as a community based treatment and crisis stabilization program for adults with mental illness. An on-site, full-time psychiatrist, certified in adult and child treatment, serves as Medical Director and oversees all treatment programs as well as authorizes necessary billing and insurance claims. Each noted program is staffed and managed by County employees including Adult and Child Intake/Crisis staff that operate 24/7 on site, including weekends and holidays. Potential Emergency Detentions are assessed by County staff in an immediate response system using consultation with the Medical Director as needed. Depending upon acquity of presenting issues, including safety, determinations are made for immediate intervention including inpatient hospitalization, group home or other crisis stabilization placement. St. Agnes in Fond du Lac, and Winnebago Mental Health Institute are the primary facilities used for Emergency Detentions. Private hospitalizations are also used when appropriate. Non-crisis community requests or referrals for services are also managed by our staff, who assess immediate and longer term needs with consumers, and then connect them to the needed services by written and oral discussion with the appropriate manager and staff. The Intake staff have immediate and open access to the Medical Director as well as to managers as needed.

Overall management of the Behavioral Health service delivery system is accomplished as a shared responsibility of the management team and staff. Managers and staff are cross trained in use of the various mental health programs and funding sources and every attempt is made to capture available funding sources while meeting consumer needs. Jefferson County has developed a comprehensive system to promote recovery and maximum use of community based resources within a highly integrated county provided system. Contracts for consumer services are also used in some areas such as the Comprehensive Community Services. Providers then receive training about recovery, treatment, service plans, and billing. Purchases of service contracts with these providers reflect these expectations.

BEHAVIORAL HEALTH DIVISION TEAMS

Mental Health and Alcohol & Other Drug Abuse Clinics

Intoxicated Driver Program

Community Support Program

Community Recovery Services

Comprehensive Community Services

Emergency Mental Health (Crisis)

Mental Health and Alcohol and Drug Outpatient Clinic and Intoxicated Driver Program

~ Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into each person's plan~

The Mental Health team strives to provide person centered and recovery focused services, and is committed to delivering evidence based practices. Over the last year, we again experienced an increase in the need and demand from our residents for Mental Health and Substance Abuse services. In particular, we noted an increase in the need for heroin and addictions services. The chart below is a visual representation of the increase of 598 individuals.

Client Visits for Mental Health Services

2012	12424
2011	11826
2010	9920

The Mental Health, and the Alcohol and Other Drug Abuse (AODA) Outpatient Clinic serve primarily adult Jefferson County residents with mental health and substance abuse concerns. In 2012 there were 234 new consumers opened to the Mental Health clinic and 183 new consumers opened to the AODA clinic. As the chart below indicates, the clinic provided mental health services to 615 individuals and substance abuse services to 288 individuals.

	2008	2009	2010	2011	2012
MH Clinic	294	332	478	541	615
AODA Clinic	246	207	217	225	288
Totals	540	539	695	766	903

Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into clinic services. A treatment plan is created using the consumer's own strengths and resources to increase their potential for leading the life they want. Services are provided in the least restrictive manner; decreasing the disruption of the individual's life while still providing for recovery.

The clinic staff consists of a Medical Director/Psychiatrist, seven full-time staff with master's degrees in Social Work, Counseling or Psychology, one of whom works part-time in the jail, and a Community Outreach Worker and six of these clinic staff members have their substance abuse specialty license and one staff member is currently in the process of obtaining this licensure.

The clinic is also responsible for overseeing civil commitments and in many cases, providing treatment for the individual. Under WI § 51, persons who are assessed to be dangerous to themselves or others and have a

mental health disorder may be detained involuntarily. If the court determines that these persons need to be treated, they are placed under an order for treatment, typically for 6 months. The person can seek treatment from the clinic, or if the person has other resources, by another area provider. Clinic staff provided mental health services to an average of 235 people on a given month in 2012, an average of 44 of those individuals were court ordered. Clinic staff are then responsible for supervising the commitment period and ensuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

Under Wisconsin statutes (51.45), a person incapacitated by alcohol can be placed under protective custody by a law enforcement officer and taken to an approved detoxification facility. Prior to discharge, the individual is informed of the benefits of further diagnosis and appropriate voluntary treatment. Upon discharge from such facility, our department is then responsible for arranging transportation for these people, whether it's via Human Services staff or communicating with and arranging for family to provide transportation. If there is a concern about the individual's well-being, department staff meet with the individual face to face to complete an assessment and the appropriate referral is made; which can be an emergency detention, voluntary hospitalization, residential treatment, intensive outpatient, or outpatient services to include individual and possibly group therapy.

Public Intoxication Data for Jefferson County

	2010	**2011**	**2012**
Admissions	101	122	67
Individuals	75	91	54
Individuals with multiple admissions	8	16	5
Days	113.6	119.64	74
County Expenditures	$44,778	$58,291	$28,642

In reviewing individuals with multiple detoxifications admissions; three of the five individuals, completed residential treatment, a forth participated in outpatient treatment, and the fifth individual is considering treatment.

Counties are mandated to provide and Intoxicated Driver Program (IDP) (HFS62). Each county is responsible for establishing and providing substance use assessments of drivers who have received an operating while intoxicated (OWI) conviction. The assessment can be ordered by the court or the Department of Transportation. The IDP assessor completes an assessment using the Wisconsin Assessment tool. A driver safety plan is developed based on the results of the assessment. A person can be sent for either education if a substance disorder is not found, or treatment if a substance disorder is found. The individual is responsible for completing the Driver Safety Plan within a year's time. Failure to complete the driver's safety plan will result in the driver's license remaining revoked. In addition to doing the assessments, the assessor is responsible for monitoring the individual's compliance with the Safety Plan. The clinic has one full time assessor.

In 2012, the IDP program completed 355 assessments and driver safety plans. This was a 4% decrease from 2011. Of those 355 assessments in 2012, 181 were first time offenders. This number accounts for 51% of the assessments. 88 were second time offenders, 48 had three lifetime OWI's, 20 had four lifetime OWI's, and 14 had five or more lifetime OWI's. The remaining four assessments were voluntary or prior to conviction.

Group Dynamics is a 24 hour education program for first time offenders. Multiple Offenders is a 36 hour education program for individuals with more than one OWI offense. 148 offenders were referred to Group Dynamics and 29 were referred to the Multiple Offender Program. A total of 166 individuals were referred to outpatient substance abuse treatment. Of those, 62 were referred to the Jefferson County Human Service Outpatient AODA Clinic primarily due to lack of insurance. The clinic provided AODA services to an average of 142 people per month.

Operating While Intoxicated

	2012
1st Offense	181
2nd Offense	88
3rd Offense	48
4th Offense	20
5th Offense or more	14
Voluntary	4
TOTALS	355

Consumer Satisfaction

In 2012, the Outpatient Clinics conducted a consumer satisfaction survey. The ROSI (Recovery Oriented System Indicators) measures the satisfaction of the participant and the degree to which its services are recovery oriented. The survey asks 42 questions regarding the participant's experiences in the past six months. The choice of responses range from strongly disagree to strongly agree and includes an option of does not apply to me. The questions rate 6 areas of service: Person Centered Services, Barriers to Success, Empowerment, Employment, Staff Approach and Basic needs. Consumers were asked to complete the anonymous survey by reception staff, prior to meeting with their clinician/counselor. 72 surveys were completed which is a 27% increase from last year.

Consumer Survey Results

	ROSI Overall Mean	Scale 1— Person Centered	Scale 2— Barriers	Scale 3— Empowerment	Scale 4— Employment	Scale 5— Staff Approach	Scale 6— Basic Needs
Average for all consumers	3.4	3.7	2.1	3.4	3.6	1.6	2.9
% with mostly recovery-oriented experience	83.3%	87.3%	31.9%	86.1%	81.7%	64.8%	62.9%
% with mixed experience	16.7%	11.3%	59.7%	12.5%	14.1%	26.8%	21.4%
% with less recovery oriented experience	0	1.4%	8.3%	1.4	4.2%	8.5%	15.7%

In looking at the means, these numbers can range from 1.0 to 4.0 with 4.0 being the highest; although scales 2 and 5 (the shaded areas) are negatively phrased which means a low mean represents a more recovery oriented experience.

The overall mean went up in 2012 a tenth of a percent from 2011. Using a person centered approach continues to be an area of strength and the percentage of individuals with mostly recovery oriented experience increased 3% from 2011. Staff continue to support consumers in self-care and wellness. Staff treat consumers with respect; they listen carefully, focus on strengths, and see consumers as an equal partner in their treatment program. The low percentage in staff approach continues to show positive results.

Basic needs is an area of only average score. 45% of consumers surveyed indicated they do not have enough money to live on. 71.8% of consumer surveyed indicated they have housing they can afford.

REVIEW OF 2012 GOALS

1. **Implementation of person centered planning**: Clinic staff were trained in person centered planning on December 15th 2011 by Wisconsin Department of Health Services Division of Mental Health and Substance Abuse Services. Person Centered planning was implemented into all treatment plans within the first quarter of 2012.

2. **All behavioral health staff trained in Cognitive Behavior Therapy:**

3. **Implement Cognitive Behavioral Therapy into treatment plans**: Clinic staff have implemented cognitive behavior therapy into treatment plans when appropriate. CBT is being utilized in both group and individual sessions.

4. **Quality improvement initiative by continuing to participate in NIATx projects:**
    a. In 2012, the clinic participated in Wisconsin Strengthening Treatment Access and Retention-State Implementation (STAR-SI) program which is a cooperative effort of the Wisconsin Division of Mental Health and Substance Abuse Services, the University of Wisconsin Department of Family Medicine and participating County and treatment agencies. This project focused on the exploration of electronic health records and assisted us in narrowing down potential electronic health record options.

    b. An additional NIATx project was the implementation of the Patient Health Questionnaire (PHQ-9). The PHQ-9 is a nine item patient health questionnaire that is validated for measuring depression severity.

    c. At the end of the 2012, an additional STAR-SI project was commended looking at the opening process and increasing revenue.

5. **Drug task force training for clinic staff:** Jefferson County Drug Task Force provided training to clinic staff in 2012 and will be providing updated training again in 2013.

6. **Uniform Placement Criteria (UPC) training for all clinic staff:** Staff were trained on February 27th, 2012 on the application of the Wisconsin Uniform Placement Criteria (WI-UPC) by the Wisconsin Department of Health Services Division of Mental Health and Substance Abuse Services Bureau of Prevention, Treatment and Recovery.

7. **Increase the number of consumer satisfaction surveys received by at least 10%**: ROSI survey responses increased by 27% in 2012.

8. **Integrate health care questions into our assessment and facilitate follow-up with primary care provider**: Health care questions are included in the personal history assessment (the assessment tool for the clinic). Staff follow up with primary care is done when appropriate and encouraging consumers to seek medical care is done when needed.

9. **Implement standardized rating and tracking of consumer outcomes:** The Patient Health Questionnaire (PHQ-9) was implemented in 2012.

2013 Evidenced Based Practices

1. Motivational enhancement therapy techniques-- (MET) is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence and achieve lasting changes for a range of problematic behaviors. This intervention has been extensively tested in treatment evaluations of alcohol and other drug use/misuse. (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=107). The clinic is utilizing this therapy protocol in both group and individual sessions.

2. Medication assisted treatment for opioid addiction via the use of Buprenorphine. (http://www.ncbi.nlm.nih.gov/books/NBK64164/). The clinic ran four different Buprenorphine maintenance treatment groups throughout 2012. There was an average of 85 consumers in the Buprenorphine maintenance program.

3. Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It has been conducted in both group and individual sessions. Seeking Safety consists of 25 topics that can be conducted in any order. At this point, Seeking Safety is the most studied treatment for PTSD-substance abuse. Twelve outcome studies are completed, plus one dissemination study. (http://www.seekingsafety.org). The clinic completed one round of group therapy utilizing the Seeking Safety material in 2012.

4. Cognitive behavior therapy (CBT) is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. (http://www.nacbt.org/whatiscbt.htm). All clinic staff were trained in cognitive behavior therapy and CBT is used in both group and individual sessions.

2013 GOALS

1. **Implementation of the Brief Addiction Monitor (BAM**). The Brief Addiction Monitor is a 17-item monitoring instrument covering important substance use related behaviors to support measurement-based care and outcomes assessment. Of the 17 items, 4 are concerned specifically with alcohol or drug use. The remaining items address aspects related to substance use, recovery, and treatment that span a number of life areas considered important for a multidimensional assessment of substance abusing patients and include interpersonal relationships, psychological/medical problems, and finances. The BAM measures three summary factors: Recovery Protection, Physical and Psychological Problems, and Substance Use and Risk.

2. **Drug Task Force training for clinic staff in 2013:** To ensure staff are up to date on current drug trends in Jefferson County.

3. **Implementation of self-care/wellness plans for clinic staff.**

4. **Further training for staff in cognitive behavior therapy including model adherence.**

5. **Quality improvement initiative by continuing to participate in NIATx projects:**

a. Track PHQ-9 (patient health questionnaire) data throughout 2013: Participate in NIATx project on tracking clinical outcome measures with the STAR-QI project.

b. Continue to participate in STAR-QI project on increasing revenue

6. **Further implementation of evidenced based practices for dual diagnosis.**

7. **Implementation of electronic health records.**

8. **Further enhancement of all monitoring procedures:** opening process, documentation and closing procedures.

* * *

COMMUNITY SUPPORT PROGRAM

~Advancing mental health services for people with severe and persistent mental illness~

The Jefferson County Support Program was developed in December of 1996 and began receiving clients in January 1997. This Community Support Program was certified on June 1, 1997 and is certified under HSS 63 as a Community Support Program. The program was certified by the state in May 2012 and was recertified for two years at that time.

In its fourteenth year of operation the Jefferson County Community Support Program provided services to 152 consumers ranging in age from 12 to 77. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar, major depression and various anxiety disorders. In 2011, 15 consumers were admitted and 14 were discharged.

Jefferson County Human Services CSP has grown significantly. In 1998, it served less than thirty consumers, and employed five and a half staff. In 2012, the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/medical director; program assistant; two full time mental health technicians both of whom were also peer support specialists; one vocational specialist; one part time nurse; and eleven case managers/CSP professionals.

Community Support Programs in the state of Wisconsin have an extensive and well researched history. The original CSP started out of Mendota Mental Health Institute in the 1980's and is now known as ACT. The ACT model has received numerous awards from the American Psychological Association for its research. It is now used on a nationwide and international basis to advance the mental health services for people with a severe and persistent mental illness. It has proven effective for reducing symptoms, hospital costs, and improving overall quality of life. The research has shown that for outcome measures to be similar for consumers in other CSP's it is important to have as much fidelity to the ACT model as possible. Jefferson County CSP continues to have very high fidelity to the ACT model and the team functions as an ACT team. It is believed that this led to better outcomes for our consumers.

In accordance with the ACT model, the Jefferson County CSP has the capacity to function as a mobile in-patient unit. The program provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, opportunities for social interactions, individual and group psychotherapy, medication management and distribution, education and money management and budgeting, coaching in activities of daily living, including how to maintain a household and homemaking skills, crisis intervention, case management and supportive services to people with severe and persistent mental illness. All consumers in the CSP, at some time, have had acute episodes that have resulted in the need for frequent psychiatric hospitalizations and emergency detentions to institutes for mental disease. Consequently, in the past, their lives were disrupted and they were removed from their community of choice. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

Jefferson County's CSP also provides consumers the evidence based practices (please see sections below for detail) of Illness Management and Recovery, Integrated Dual Diagnosis groups for those with substance abuse issues, Supportive Employment, Seeking Safety, Cognitive Behavior Therapy and DBT. Consumers also are encouraged to complete Wellness Recovery Action Plans; these plans specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

It is believed that due to these combined efforts the Jefferson County CSP was successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.

Some of the specific accomplishments for the year 2012 include:

1. Five consumers, who were on Chapter 51 orders, successfully completed his or her court requirements.

2. Two consumers resumed managing their own money as their skills were enhanced and the protective payeeships were dismissed.

3. Twenty four percent of consumers worked in a job of their choosing.

4. Eighteen consumers served the community through volunteer work at such places as Fort Atkinson Memorial Hospital, St. Vincent's, nursing homes, Rock River Free Clinic, Food pantry, CSP consumer council, and Horizons Drop In Center.

5. Five consumers pursued educational goals. Four of the consumers attended the UW Whitewater, and three pursued an HSED degree from MATC.

6. Two consumers moved out of residential placements into their own apartments.

7. All goals were met from last year's report. These will be reviewed below in detail.

REVIEW OF 2012 GOALS

1. **Implement Collaborative Documentation across the team.**
   Collaborative Documentation involves completing the documentation of the treatment session with the consumer. This is beneficial on several levels. The consumer is aware of and agrees to the content of the session and what information is being placed in the treatment record. This increases consumer participation in their recovery process. Staff productivity is also enhanced since their documentation time is captured in the billable time with the consumer and the note is complete at the end of the session and does not have to be done at a later time.

   In 2012, the team was trained in Collaborative Documentation and the rationale for moving to this model was conveyed. Fifty percent of the case managers have implemented this as standard practice in their sessions. Some barriers to complete implementation that have arisen include consumers objecting to the process due to paranoia or preference, staff expressing difficulty in finding the process distracting while conducting the session, and some of the CSP contacts occurring while transporting the consumers or conducting psychosocial rehabilitation in the community.

   Additional education on the model will be done in 2013 as we move to complete implementation with the rolling out of the electronic record system.

2. **Run the NIATx process and implement projects throughout the year.**
   NIATx is an evidenced based rapid change cycle model where changes are implemented for process improvement. The changes are focused on reducing waiting times and increasing retention in behavioral health treatments. The model consists of four stages including Plan, Do, Study, and Act. In the Act phase a decision is made to adopt, adapt, or abandon the change.

   In 2012, a change team continued at CSP with six members. The goal of this year's NIATx project was to develop a medication recording system at CSP. This was combined with goal number six and the change cycles will be discussed under that goal.

3. **Train the team in CBT and implement this in appropriate treatment plans.**
   In 2012, biweekly training sessions were run during Wednesday team meeting to read and discuss "Cognitive Behavior Therapy – Basics and Beyond," by Judith S. Beck. The team discussed core concepts,

treatment strategies, and modifications to allow for implementation with a wider variety of consumers in the program. Case examples were utilized where the treatment was being applied and difficult issues were problem solved by the team as well. Case managers are currently using core concepts of CBT with twenty three consumers. The team also worked on implementing some of the techniques such as assigning commitments or homework weekly and setting an agenda for the session with most consumers in CSP.

4. **Have a conversation with all consumers in treatment plan meeting about health goals and track completion rate of these goals for the year.**
   Consumers with severe and persistent mental health issues face a variety of health challenges. Many use illegal substances, prescription medications, or alcohol to deal with stress and symptoms. The incidence of smoking cigarettes is higher than in the general population. Medications that are prescribed to treat their mental health symptoms can lead to high blood pressure, high triglycerides, high cholesterol, diabetes, and obesity. Studies have shown that the lifespan for someone with a severe and persistent mental illness averages at least twenty years less than someone with the diagnosis. The field is putting more emphasis on treating physical health conditions along with mental health symptoms and that has been a focus in the CSP for 2012.
   Sixty three or 42% of the consumers served in the CSP in 2012 were working on some sort or physical health issue in their recovery plans with their case manager. Some of these goals focused on reducing substance abuse, losing weight, eating healthier, exercising, getting better sleep, or quitting smoking.

5. **Participate in the UW-NAMI Tobacco Cessation research project.**
   The CSP applied to be a part of the UW-NAMI Tobacco Cessation research project. The study will involve utilizing peer support specialist to promote quitting smoking and to assist consumers in meeting this goal. Jefferson County was granted access to the study but due to difficulty in the program finding peer support specialist to conduct the treatment protocol the study was not rolled out here in 2012.

6. **Improve the medication recording system for CSP.**
   This goal was combined with goal number two, the CSP NIATX project for 2012. A variety of strategies were attempted involving the program manager tracking medication changes and printing them out for Dr. Haggart and getting updated physician order sheets from the pharmacy, Assisted Living Pharmacy Service (ALPS), each time a medication was changed. Numerous problems had arisen and it was difficult to track the changes for a variety of reasons. We requested that ALPS develop a web site where the current lists could be accessed. This was accomplished late 2012. The program assistant is now printing a list for each psychiatric appointment. Case managers are maintaining lists for consumers that do not utilize ALPS.

7. **Increase our use of peer support.**
   In March, a new mental health technician was hired. This individual is a certified peer support specialist. She currently works full time with a number of individuals. Currently, both mental health technicians are peer support specialists.

8. **Continue to monitor and improve the quality of our services through tracking outcomes in the CSP database and through the ROSI survey.**
   Closer attention was paid to tracking outcomes in the consumer database. In 2012, ninety five emergency visits were tracked for CSP consumers. This averages to .63 visits per each consumer in the CSP in 2012, down from .71 ER visits per consumer last year.

   Community Support Program consumers had 28 tracked hospital stays in 2012 accounting for 246 hospital days for the year. The average hospital admission lasted 8.9 days. There was an admission rate of one in five consumers for this year. In 2011, there were 35 admissions for 300 total days. This represents a decrease for 2012.

There were 65 tracked admissions to the Lueder House in 2012 for a total of 994 Lueder House days. The average admission length was 15.3 days. This is up from the 7.5 day average in 2012. This is likely due to having a consumer who was homeless staying for quite some time and two other consumers with significant relapses that had extremely long admissions. It continues to be true that our Lueder House admissions are higher as we divert more people to this facility rather than admitting them for hospitalization.

In 2012, the CSP consumers met 64.9% of their treatment goals that were identified in their individualized recovery plans.

This data will continue to be reviewed and tracked in 2013, with an emphasis on reducing the utilization of the emergency rooms, hospitals, and Lueder House while increasing the percentage of recovery plan goals met.

We again implemented the Recovery Oriented System Inventory (ROSI). The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation. It is the recommended consumer satisfaction measure by Wisconsin Department of Health.

Consumers of the CSP were sent a ROSI survey to complete anonymously. Forty eight consumers completed this survey. The following chart further explains the ROSI and summarizes the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 – Barriers	Scale 3 – Empower	Scale 4 – Employ	Scale 5 – Staff Approach	Scale 6 – Basic Needs
Average for All Consumers	3.3	3.5	2.0	3.4	3.5	1.8	3.2
% w/ Mostly Recovery-Oriented Experience	71.4%	85.7%	54.2%	85.7%	68.8%	67.3%	79.2%
% w/ Mixed Experience	26.5%	8.2%	25.0%	12.2%	25.0%	14.3%	12.5%
% w/ Less Recovery-Oriented Experience	2.0%	6.1%	20.8%	2.0%	6.3%	18.4%	8.3%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.) The percentages in Rows 3-5 have been adjusted for Scales 2 and 5 so they have the same meaning as the other scales.

The means from 2012 continue to show positive results. These results continue to indicate that consumers feel empowered by CSP staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized.

The results were consistent with the results that we collected in 2011.

9. **Continue to implement and monitor the fidelity of the evidence based practices and begin using rating scales to measure the effectiveness of treatment.**

a) **ACT Fidelity score: 96**

Our CSP team continues to function as an ACT team. Fidelity is rated on a five point scale, with five meaning full fidelity. We rated 1 in two areas this year One of these areas is related to staffing patterns. Full fidelity involves having two nurses per one hundred consumers. We only have eight hours of nursing time to provide for the needs of one hundred fifty one consumers over the year. There are no plans to address this currently. The second area involves the number of consumers we have attending monthly treatment groups for dual diagnosis. While we see an increase in substance abuse issues for the consumers we are currently serving, many of these individuals remain in the engagement phase of treatment where they are pre-contemplating change. They are not yet ready to engage in a treatment group. The team continues to use Motivational Interviewing to enhance engagement and motivation when working with people with a dual diagnosis. In other areas, the team scored in a two to five range. This indicates very good fidelity to the model. The fidelity score continues to drop from year to year as more consumers are served and nursing time, psychiatrist time, and the supervisor time is not increased to lower the ratio to the consumers. The fidelity would also improve with the addition of a full time vocational specialist and substance abuse specialist.

b) **Illness Management and Recovery. Fidelity score: 55**

We did offer this curriculum as a group this year and also worked on it with several members of the CSP independently. The team has over the past year worked on completing the Illness Management and Recovery curriculum in whole or in part with a number of individual consumers. Nine individuals worked on Illness Management and Recovery. New admissions to the CSP are encouraged to complete the curriculum.

c) **Integrated Dual Diagnosis Fidelity score: 51**

We continued to use motivational interviewing and approached treatment in stage-wise interventions. We work as a multidisciplinary approach with time-unlimited services. We offer pharmacological treatments and promote health and wellness. We continue to be low in the percentage of people with co-occurring disorders who participate in both treatment and self-help groups. We are seeing an increase in individuals being served who are dually diagnosed. Our fidelity to the model is low. We could improve this by increasing substance abuse training to staff and continuing to offer treatment groups.

d) **A Seeking Safety group was offered for women in 2012 (No Fidelity Score)**

Seeking Safety is an evidenced based practice which provides treatment for individuals with addictions and trauma histories. The group ranged from six to eight people and had excellent retention. The curriculum was also done with several individuals in symptom management sessions with his or her case manager.

e) **Supported Employment Fidelity score: 86**

Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. A rapid job search is conducted. In 2012, the job search began even before DVR services were established with some consumers. There is a significant wait time for DVR services at the present time. Supports follow the person and occur in the community. The vocational specialist does not spend the majority of his time providing vocational supports. This person does not have a case management caseload.

In 2012, there continues to be an individual working to providing vocational services to CSP and CCS consumers. This program followed the evidenced-based model for supported employment developed by Dartmouth College. The supported employment program also served as a vendor for individuals that were in the CSP, and were referred by the Department of Vocational Rehabilitation (DVR). As a vender of DVR services, the vocational specialist provided services related to vocational assessments, job placement, job coaching, benefit analysis, and job shadows, and assistance in arranging transportation. We funded employment services in 2012 through both DVR and CRS.

Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Supports were offered to the employer as well to maintain the job once the consumer began working.

Many of the consumers served by the vocational program gained or maintained employment. With the consumers already working, thirty six consumers had employment at some time throughout the year. This led to 20 percent of CSP consumers working. Some of the places of employment were at group homes, supported apartments for people with disabilities, restaurants, cleaning at a wayside, self-employment, factory work, psychiatric hospitals, the outlet mall, and an auto dealer. The positions that were filled in the community were: grounds maintenance, CNA, custodian, group home worker, drivers for people with disabilities, delivery driver, self-employment, math tutor, retail associate, repair person, and baker. Other consumers remained employed through Opportunities, Inc. until they could find community employment.

Furthering education continues to be a focus of the CSP vocational program. A total of seven consumers from the CSP attended post high school programs in 2012. One consumer attended UW Whitewater pursuing a degree in Biology. A second consumer is at UW-Whitewater pursuing a degree in education. One attended a graduate class at UW-Whitewater. One consumer transferred from MATC to UW-Whitewater to pursue a career in social work. The final three CSP consumers attended MATC to obtain their HSED degree. Depending on what the person wanted and needed, CSP staff helped people register for classes, coordinate services with the student disability services, obtain financial aid, manage their symptoms while in classes and provide transportation to school.

In summary, CSP consumers have achieved their employment goals by following the evidence-based model of supportive employment for people who have a severe mental illness.

2013 GOALS

1. Implement the electronic health record system.

2. Run the NIATx process and implement projects throughout the year.

3. Continue to offer training in evidenced based practices at the CSP.

4. Implement a system to monitor physical health issues and provide appropriate treatments and interventions.

5. Continue to monitor and improve the quality of our services through tracking outcomes in the CSP database and through the ROSI survey.

6. Continue to implement and monitor the fidelity of the evidence based practices and begin using rating scales to measure the effectiveness of treatment.

7. Address staff wellness issues in team meetings and promote stress management techniques such as mindfulness.

8. Identify and begin to implement standardized outcome measure tools.

9. Create a CSP work group to address limits in staffing and problem-solve ways to continue to maintain the program without a waiting list.

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COMMUNITY RECOVERY SERVICES (CRS)

~Providing qualifying consumers with services to move forward in their recovery goals~

Community Recovery Services provide qualifying consumers with services to move forward in their recovery goals. Services that can be provided are peer support, employment services and community living supportive services. The program is funded through Medicaid. In 2012, eleven consumers were served in the program. There was one admission and two discharges. Two of the consumers enrolled received supportive employment services. One of those consumers was employed full time at the end of 2012. The nine other consumers received community living supportive services. Two of these individuals were able to reduce their supports in the community. One individual moved to a group home with fewer individuals closer to his natural supports. The other individual was able to move into his own apartment in the community.

In 2012, the program focused on quality assurance and monitoring in regards to the recovery notes provided by the CLSS supports. This included multiple trainings of programs and direct service providers in the note format provided through the state auditor in December 2011. Quality was monitored and frequent contacts were made with providers to resolve problems. CRS policies were established for billing, monitoring, and auditing the program.

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COMPREHENSIVE COMMUNITY SERVICES PROGRAM (CCS)

~Reducing the effects of an individual's mental health and/or substance use disorders; assisting people in living the best possible life, and helping participants on their journey towards recovery~

The Jefferson County Comprehensive Community Services Program (CCS) completed its fifth full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license has been renewed every two years, most recently March 2013.

Program Description

CCS is a voluntary, recovery-based program that serves children (0-18), adults (18-62) and senior citizens (63-100) with serious mental health and/or substance abuse disorders. As stated on the State's, Bureau of Mental Health Prevention, Treatment and Recovery website, CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery.

CCS offer an array of psychosocial rehabilitative services which are tailored to individual consumer. These services include: assessment; recovery planning; service facilitation; communication and interpersonal skill training; community skills development and enhancement; diagnostic evaluations and specialized assessments; employment related skills training; physical health and monitoring; psycho education; psychosocial rehabilitative residential supports; psychotherapy; recovery education and illness management; and additional individualized psychosocial rehabilitative services deemed necessary.

General data

During 2012, 84 consumers ranging in age from 8 to 64 received services. This is an increase from 2011 when we served 69 consumers. Throughout 2012, 38 new consumers were admitted and 22 consumers were discharged. Of the consumers admitted to the program, 25 were children and 13 were adults. Of the consumers discharged, 11 were children and 11 were adults. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, and substance use disorders.

The CCS staff consists of a Psychiatrist/Medical Director and a CCS Service Director. As of January 2013 there are 5 full time CCS Service Facilitators, and a full time job developer.

Consumer Satisfaction

The CCS program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 11 adult respondents this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff is doing well in these areas. These two areas remain below a mean score of 2. This year's ROSI showed percentages in all categories but one were up from last year. The one category, barriers, did not really change. The large changes were in empowerment and staff approach where we scored 100% in both categories for being mostly recovery oriented. Another significant change was in our supported employment score. The job developer worked very hard this last year to get people jobs that match their interests and that they wanted. The job developer continues to use the evidence based model for supported employment.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	Scale 1 person centered	Scale 2 Barriers	Scale 3 Empowerment	Scale 4 Employment	Scale 5 staff approach	Scale 6 Basic needs
Average for all consumers	3.3	3.5	1.9	3.5	2.9	1.2	3.0
% with mostly recovery oriented experience	80.0%	80.0%	40.0%	100.0%	60.0%	100.0%	62.5%
% with mixed experience	20.0%	20.0%	60.0%	0.0%	40.0%	0.0%	37.5%
% with less recovery oriented exp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Monetary benefits

In 2012 the CCS program was reimbursed $392,619.72 from Medicaid for services provided to consumers. This is an increase of $64,948.64 from 2011.

Children

In 2012, the CCS program served 42 children, ages 8 to 17; of these children, 28 were males and 14 were females. Twenty-six of the children resided at home all year or with a relative, six moved from out of home back home or to a relative's home, three lived in a group home, six lived in a foster home/treatment foster home, one child was placed in a residential treatment facility.

During 2012 four children had a mental health commitment order. Four young adults were employed.

In 2012, 25 children were admitted to CCS and 10 were discharged. Of the ten discharged, three children moved out of county, three children chose to withdraw from the program, and one child met their discharge criteria, one child was admitted into residential treatment, one 17 year old was admitted into department of corrections programming out of the county, and one child was transferred to other services.

Of the 41 children that CCS served throughout 2012, 8 of them were admitted for psychiatric hospitalizations. Four of the children had voluntary admissions; four of the children had just one involuntary admission. The voluntary hospitalization days totaled 50. The involuntary admissions to an institute such as Winnebago Mental Health Institute totaled 76. This was for one child who then went into residential treatment. Involuntary admissions to Wheaton hospital totaled 28 days.

Adults

In 2012, the CCS program provided services for 42 adults aged 18-64. Of these adults, 9 were males and 33 were females. Thirty-five people lived in their own apartment/home, two people resided in a group home, one person resided in an adult family home, and two people resided in a supervised apartment. During 2012, one person moved from a group home to live with a family member and one person moved from an adult family home into their own apartment. Four adults were under a guardianship. Of the four adults under a guardianship, two also had mental health commitment orders. Eleven individuals had mental health commitment orders with two individual not having their order continued.

In 2012, thirteen adults were admitted to CCS and eleven were discharged. Of the people discharged, one individual was transferred to the outpatient clinic for services, one person transferred to the Community Support Program (CSP) due to increased symptomology and the need for additional services. Three individuals died of natural causes, two individuals moved out of county, two individuals did not engage in services, and two individuals were discharged for successfully meeting discharge criteria.

Sixteen adults used a total of 128 hospital days, 34 Mendota/Winnebago/IMD days and 249 Lueder House/crisis stabilization bed days. Two adults accounted for the IMD days, ten for voluntary hospitalizations days, and eleven for crisis stabilization days. One individual accounted for 97 of the 249 days for crisis stabilization.

Elderly

In 2012, the CCS program did not serve anyone who was considered elderly.

Recovery Plans

Consumer recovery plans are reviewed every six months. Thirty-three consumers participated in the CCS program long enough to have two plans in 2012. Overall, 58% of their objectives were met. Eighteen consumers were able to meet 100% of their goals on at least one treatment plan. Eleven consumers were able to complete 100% of the objectives for the year. The children met 49% of their goals. Seven children were not able to meet any objectives during a 6 month period. Of the seven, three only had one plan for the year and four were moved into an out of home placement during the 6 month period. The adults met 63% of their goals. We continued to use person centered planning when doing recovery plans. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural supports. Consumers have reported feeling in charge of their services and being able to direct the team in their needs. Family members and providers feel that they can easily read and understand the plan. Family members and other natural supports feel more connected as they are written into the plan providing services to the person. The plans also inform the consumer of the services they are to receive. This increases accountability since everyone on the team knows his or her responsibility in assisting the consumer in building recovery.

Additional service providers

In 2012, the CCS program contracted with nine providers.

- Five individuals provided contracted therapy services. These individuals provided a mix of in-home and agency individual and/or family therapy.
- Four certified peer specialists assisted the CCS program last year. These trained peers provided support and advocacy for persons in their journey of recovery.

As therapists, psycho-social rehabilitation workers and peer support specialists employ psychosocial rehabilitation practices; their services were billable to Medical Assistance through the CCS program.

2012 Evidenced Base Practices

CCS provided the following evidenced based practice groups; Seeking Safety group and Managing Life group (Dialectical Behavior Therapy). The groups were co-facilitated with a clinic therapist and with a certified peer specialist. Individually people were offered Pyscho-education, Illness Management and Recovery, Cognitive Behavior Therapy, Dialectical Behavior Therapy, and Supported Employment.

Fidelity scales was completed for supported employment for 2012. A fidelity scale indicates how accurately you adhere to the true model.

- Supported Employment Fidelity score: 86
  Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. A rapid job search is conducted. Supports follow the person and occur in the community. The vocational specialist now spends the majority of his time providing vocational supports. He is also providing some psychosocial rehabilitation services to adolescents in CCS and some consumers in CSP.

  Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Supports were offered to the employer as well to maintain the job once the consumer began working.

  During 2012 CCS had nine individuals working, three enrolled and attending college/technical college, and one individual looking for employment.

CCS Coordinating Committee

The CCS Coordinating Committee is currently comprised of consumers and staff. The committee meets quarterly at Human Services for at least one hour. The committee continues to focus on recruitment and retention of members.

The CCS Coordinating Committee is submitting the following recommendations for the CCS program in 2013.

- Establish a CCS Coordinating Committee Board in the New Year and have the board make a one year commitment.
- Start psychoeducation for consumers and support persons of consumers in the CCS Program
- Review CCS policies at every CCS Coordinating Committee meeting.
- Offer groups for male consumers
- Provide opportunities for kids to socially integrate in normalized activities.
- Offer a relaxation group
- Offer an adult social skills group that uses crafts
- Have a teen girl group about healthy boundaries and relationships
- Have a group for teens and young adults on independent living skills
- Offer a coping skills group that can be age specific (children, teens, young adults, and adults)
- Have consumers and peer support specialist help lead various groups with service facilitators
- Have the CCS Coordinating Committee meetings start with policy, Quality Improvement Ideas, and other areas of need and then be a socialization time for consumers and support people.
- Redo the CCS Brochure to make it more eye appealing and have it available in the community.

REVIEW OF 2012 GOALS

1. The CCS policies and procedures will be reviewed and updated by December 2012 with the input of the CCS coordinating committee. *This goal was met and policies were written regarding paperwork timelines.*

2. Review and update training protocol and procedures for new staff by August 2012. *This was completed and will be implemented for all new CCS staff.*

3. Start each Monday staff meeting with 10 minutes of wellness to decrease staff stress by May 2012. *We were able to do this and staff participated by rotating who was leading the activity and everyone was able to share what worked for them.*

4. Develop a list of providers in our area that have expertise in trauma and attachment that would partner with CCS to provide the children in the program therapy by July 2012. *This is a goal that will continue to be worked on in 2013. A few providers have been identified but have not yet agreed to partner with CCS.*

5. Increase the number of certified peer specialists that work with the CCS program by August 2012. *This goal was met and we currently have four certified peer specialists working with the CCS program. Prior to this we had two certified peer specialists.*

6. Assess, track and integrate physical health measures while facilitating follow-up with primary care provider. *In 2012 we had 8 consumers with metabolic syndrome, 6 with high blood pressure, 4 with high cholesterol, 21 with obesity, 8 with type II diabetes, 24 with asthma, 5 with COPD, and 3 with cardiovascular problems. Due to these numbers we will continue to focus on this in 2013 to ensure consumers are following up with primary care physicians/specialists and following through on recommendations.*

7. Implement use of standardized rating and tracking of outcomes. *In 2012 we implemented the PHQ-9 for adults and will focus on tracking for children in 2013.*

8. Form a change team and initiate change project using the NIATx model. *The change team completed transformation on the counseling rooms and Dr. Haggart meeting rooms. This change increased the safety for staff and consumers. It also created a more relaxing and up to date atmosphere.*

REVIEW OF 2012 TRAINING GOALS

1. Complete staff training for Cognitive Behavioral training by December 2012. *This was completed prior to December and is being implemented in recovery plans.*

2. Compassion fatigue/vicarious trauma training for all CCS staff by December 2012. *At Monday team meetings we were devoting 10 minutes to wellness and were discussing this topic at meetings and in individual sessions. Some staff attended training related to this topic.*

3. Applied Suicide Intervention Skills training for staff by June 1, 2012. *This was completed and all CCS staff are ASIST trained.*

4. Attachment and trauma training in children for all CCS staff by April 20, 2012. *All CCS staff attended the training facilitated by Lark Eshleman.*

2013 GOALS

1. Expand CCS providers specializing in trauma and attachment for children and adolescents by December 31, 2013.

2. Assess, track and integrate physical health measures while facilitating follow-up with primary care provider by December.

3. Expand all CCS providers for children and adults by December 31, 2013.

4. Provide two groups for adults and two groups for children throughout the year. Groups can include; Seeking Safety, DBT, social skills, anger management, psycho-education, coping cat, and any other evidence based material that may fit the need of the consumers.

5. All groups will be co-facilitated by a certified peer specialist.

6. Tracking and assessing outcomes for all consumers.

7. Track the following for children:
   - ✓ Police contact
   - ✓ Permanence and stability of placement
   - ✓ Increasing problem solving techniques
   - ✓ CPS contacts
   - ✓ Delinquency referrals
   - ✓ Follow court ordered services
   - ✓ Physical/sexual aggression
   - ✓ School performance/functioning
   - ✓ Family satisfaction
   - ✓ Anxiety/depression scores
   - ✓ Trauma assessment and treatment
   - ✓ Facilitate a mental health awareness day for children/adolescents.

2013 TRAINING GOALS

1. CCS staff to obtain substance abuse specialty.
2. Training for CCS staff specific to child/adolescent mental health.
3. Training on the DSM V.

* * *

EMERGENCY MENTAL HEALTH

~Helping individuals receive crisis assessments, response planning, linkage and follow up, and crisis stabilizations services~

Our Emergency Mental Health (EMH) crisis intervention services were certified under HFS 34 in October of 2007. In becoming certified, the Department did not have to add any new services or new staff. The Department organized procedures, formalized policies, developed billing systems and trained staff across the entire agency. We continue to revise and update these policies and procedures.

In 2012, the citizen need for our Emergency Mental Health services continued. The number of crisis contacts increased from 3582 in 2009 to 5114 in 2010 to 5636 in 2011 to 5707 in 2012. These people received crisis assessments, response planning, linkage and follow up, and crisis stabilization services. Of the 319 emergency detention assessments completed, 122 people were placed in an emergency detention and 197 were diverted. Of the individuals who were detained, 62 were in response to people who were suicidal, 31 people were a danger to others, 15 people were experiencing psychosis, and 14 people were detained in other counties with venue transferred to us. Nine of the individuals that were emergently detained were residents of another county, 12 were members of family care, and 45 of the individuals we had no prior contact with.

The number of calls rose slightly last year and we were able to continue to divert people away from state hospitals. This occurs because Human Service intake workers complete a Crisis Assessment and make the decision about the need for an emergency detention. It is helpful because we have mental health professionals and a psychiatrist who are able to see people with acute symptoms on the same day and then follow them closely.

In 2012, the fourth full year of certified Emergency Mental Health services, we billed $115,739.75 to Medicaid for our services and received payment of $64,496.62.

Lastly, 100 people were served by the Lueder House, our crisis stabilization facility. We were also able to bill $417,845.60 to Medicaid for our crisis stabilization services and received payment of $126,526.43.

LUEDER HOUSE CRISIS STABILIZATION FACILITY

Lueder House is an 8 bed licensed class A community based residential facility (CBRF). This facility serves as our crisis stabilization facility and allows us to divert people from hospitalizations and keep people in the community near their providers and support people. The Lueder House is not a permanent housing option for people. It is staffed by a manager, 4 full time staff, and 2 part time staff. Our medical director/psychiatrist admits and discharges people from the Lueder House. While they are staying there he sees them up to two times per week and is available at all times for questions. The emergency mental health supervisor oversees the Lueder House manager. In 2013, two certified peer specialists will meet with people upon admission to the Lueder House. Peer support specialists will talk with consumers about his or her own recovery, about community resources, and advocate for the person. Below are the numbers from the last four years showing the number of consumers' served, total admissions, and the average length of stay.

Lueder House Crisis Stabilization

Year	Number of consumers served	Number of total admissions	Number of total days
2009	113	214	2439
2010	116	219	2133
2011	138	214	1888
2012	101	200	2221

CONSUMER SATISFACTION

The EMH program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 26 adult respondents this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff is doing well in these areas.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	Scale 1 person centered	Scale 2 Barriers	Scale 3 Empowerment	Scale 4 Employment	Scale 5 staff approach	Scale 6 Basic needs
Average for all consumers	3.0	3.2	1.9	3.1	2.8	1.6	3.0
% with mostly recovery oriented experience	52.6%	78.9%	54.2%	68.0%	37.5%	70.0%	66.7%
% with mixed experience	42.1%	10.5%	33.3%	32.0%	50.0%	25.0%	26.7%
% with less recovery oriented exp	5.3%	10.5%	12.5%	0.0%	12.5%	5.0%	6.7%

REVIEW OF 2012 GOALS

1. Reduce the number of Emergency Detentions of out of county residents placed in group homes in our county by 25%. *We were able to meet this goal. In 2012, whenever we were in contact with consumers from other counties, we called the county of residence and asked them to do the emergency detention or if they were currently under a chapter 51 mental health commitment. We have also worked with the other counties and Family Care to get crisis plans for individuals and be able to safety plan for them in the community.*

2. Send out a survey each month to receive feedback on services and how they are delivered to consumers. Each year send the ROSI survey to receive more comprehensive feedback in order to create our goals for the following year. *We were able to send out the survey throughout the year which assisted us in knowing where our strengths were and what areas needed improvement. Unfortunately we did not receive a large response from our end of the year ROSI.*

3. Send out the ROSI survey to persons who have been admitted to the Lueder House for crisis stabilization services. This data will help us to improve upon the services we are already offering. *We were able to send the survey out and in response we have instituted relaxation and seeking safety group at the Lueder House in 2012. In 2013, we will be moving forward with integrating certified peer specialist into the services offered at the Lueder House.*

4. By June 2012, implement collaborative documentation with all Emergency Mental Health staff. *Emergency Mental Health staff is using collaborative documentation. We continually look at ways to make this more efficient for staff especially when they are in the community assessing people.*

5. Meet with the Patient Care Coordinators at Fort Atkinson Hospital quarterly to review services we have provided to people when in the emergency room to determine what is working and what can be improved upon. Implement documentation for Fort Atkinson Emergency room when assessments are facilitated there by our intake workers by May 1, 2012. *This goal has been accomplished. Included in the meetings with patient care coordinators was the social worker at Fort Atkinson Hospital. We were able to come to agreement about the short summary the workers left when assessing people at the hospital.*

6. Implement and complete one NIATX change project by October 2012. *This goal was met. The change project involved the counseling rooms to make them more aesthetically pleasing and safer. The committee was involved in getting the carpets cleaned, rooms painted, laptop stands, and unneeded furniture removed from the room.*

2012 EMH TRAINING GOALS

1. All new EMH staff will attend the Applied Suicide Intervention Skills Training on May 30 & 31. *This training was held and all EMH crisis staff has been trained in this model. We were also able to train community support program staff, comprehensive community services staff, outpatient clinic staff, and adult protective services staff.*

2. Staff will attend the attachment and trauma training on April 18, 2012. *This goal has also been met. The staff was able to attend this training and there was a positive response to this training.*

3. EMH staff will be trained in Stepwise interviewing techniques by December 2012. *This goal has been met and all EMH crisis staff have now been trained in Stepwise.*

4. EMH 101 training will be offered in June and December 2012 for all new staff. *This goal was met as it was offered to all new staff throughout the year.*

GOALS FOR 2013

1. Continue to meet and collaborate with all stakeholders.

2. Implement electronic health records by December 31, 2013.

3. Meet with essential personnel from the nursing homes in Jefferson County to work with them on meeting the growing need for the elderly with mental health diagnosis by October 31, 2013.

4. Train and utilize second shift intake worker to be beneficial to the after-hours worker and response time by June 1, 2013.

5. Train and implement contracted certified peer specialists to provide services at the Lueder House by June 30, 2013. Examples of the services would be the warm line, groups, and meeting with consumers as soon as they are admitted to the Lueder House.

6. Complete NIATx project regarding crisis response times with law enforcement by August 31, 2013.

7. Have a certified peer specialist trained in brief screening and health education by November 1, 2013.

EMH TRAINING GOALS FOR 2013

1. Train children's crisis stabilization homes by August 1, 2013.

2. Train all staff to use electronic health records by December 31, 2013.

3. Continue to offer EMH 101 training to all new staff.

* * *

CHILD & FAMILY DIVISION

Keeping families together and assisting them to live in their own communities

The Child and Family Division of Jefferson County consist of Intake, Child Protective Services, Juvenile Justice Integrated Services, Coordinated Service Team (Wrap Around), Birth to Three and Busy Bee Pre-school, Child Alternate Care, Children's Long Term Services, and Independent Living. These diverse teams that comprise our Child and Family Division serve the residents of Jefferson County through a variety of multi-faceted programming. The long term goal across the division is to partner with the family to develop a comprehensive treatment plan and provide the follow up coaching and service provision for long term independent success. The primary focus of this division is providing safety, permanence, and well-being across the continuum from birth to the age of majority.

A core belief of this division is that children have the right to live in a safe environment with appropriate intervention and services that are expected to last until they reach adulthood. If safety is not obtainable in the biological home, removal may be necessary and placement could include relatives, foster care, guardianship or adoptive homes.

In 2012 the Child and Family Division focused on developing performance based contracts for all of our service providers to quantify expectations for service delivery and treatment for the families of Jefferson County. Additionally, we continued to develop and revise policy and audit procedures to capture Medicaid reimbursement in all available areas to maintain current programming and staffing levels along with traditional funding streams. Targeted professional development was a focus for the entire division as well, as we took part in classroom and long distance learning around Safety Planning, Reactive Attachment Disorder, CPR, Protective Planning, and Prescription and Street Drugs to name a few. As always a high point of emphasis was a placed on meeting state and federal indicators and performance measures as set by the Department of Health Services (DHS) and the Department of Children and Families (DCF)as well as fulfilling our various grant funding expectations from local and state grantors.

Moving forward into 2013, the Child and Family Division will be conducting wide spread outreach with local stake holders and partners such as schools, police departments and clinics. This outreach is in an effort to develop a shared understanding of one another's prospective, job duties, successes and areas for joint partnership moving forward, while building on the collaboration built thus far. We are also planning on hosting a number of community meetings with stakeholders to discuss new initiatives as a part of our implementation process. Another goal is to develop and cultivate additional resources for staff in terms of service delivery to the families we serve. Finally, we are in the process of developing a joint legal series for agency staff, the district attorney's office and area guardian ad litem (GAL) hosted by our special prosecutor to assure consistent legal practice for our juvenile cases.

The division continues to provide best practice and evidenced based practices across all teams to build on pre-existing strengths, while addressing the needs of children and families. The staff of the Child & Family Division is dedicated to the community, their colleagues, the agency and most of all to the children of Jefferson County.

CHILD & FAMILY DIVISION TEAMS

Intake

Children in Need of Protective Services

Juvenile Justice Integrated Services

Coordinated Service Team (Wraparound) & Supported Employment

Birth to Three and Busy Bees Preschool

Child Alternate Care

Children's Long Term Services

Independent Living

INTAKE

~Information must be gathered during the investigation process, including the strengths, needs, and limitations of all household members~

The Intake Unit at Jefferson County Human Services Department performs many different tasks, including receiving and screening access reports regarding child welfare and juvenile justice, conducting child welfare assessments, conducting child abuse and neglect investigations, referring families to services, and processing juvenile justice referrals. As of 2013, the Intake Unit is comprised of one Supervisor, one Access Worker, four Initial Assessment Workers, two Juvenile Court Intake Workers, as well as one second-shift Intake Worker and three After Hour Intake Workers who are co-supervised by the Emergency Mental Health Supervisor.

As noted in last year's Annual Report, Child Protective Services (CPS) provides intervention to children and families when there are allegations of child maltreatment and/or where a threat of danger to a child has been identified. This intervention is guided by the CPS Investigation and Safety Standards that are enforced by the Wisconsin Department of Children and Families, Chapter 48 State Standards, and Federal guidelines. While all CPS cases in Wisconsin require a comprehensive assessment in order to assure that children are safe and protected, not all cases need a maltreatment and maltreater determination for a family to receive services. In fact, research shows that these determinations may interfere with service provisions by creating an atmosphere that feels adversarial for families. In an effort to provide the most effective and least intrusive response to reports of child maltreatment, Wisconsin law authorized a pilot of an Alternative Response approach to Child Protective Services in a limited number of counties in Wisconsin. The Alternative Response approach to Child Protective Services focuses on engagement, teaming with families, and connecting families with both formal and informal services up front. While traditional investigations are warranted in high-risk child abuse and neglect cases, research has shown that Alternative Response is a more appropriate and successful practice in low to moderate-risk child abuse and neglect cases. The purpose of CPS intervention has always been to ensure children's safety while partnering with families to provide services that meet their needs, but unlike a traditional investigation, Alternative Response engages the family in a different way and dismisses the labels of maltreater and victim, thereby removing any substantiation determination. This can help cultivate relationships with families and increase their voluntary engagement in services. Many

communities nationwide are already using Alternative Response as a way to enhance their child welfare system and Jefferson County was selected to be part of Phase 3 of this initiative after completing a Readiness Survey. In late 2012, the staff and management that will practice Alternative Response underwent extensive training and the Intake Unit subsequently began conducting using this protocol in December 2012.

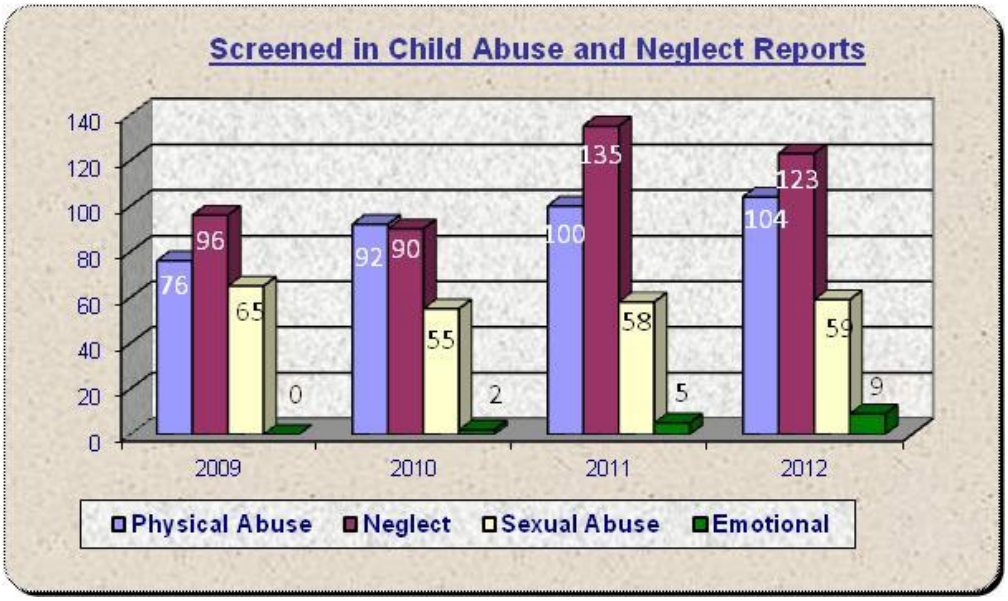
While conducting Alternative Response cases will now be one of the primary ways in which we will provide CPS intervention to families, traditional investigations will still be warranted in high-risk child abuse and neglect cases, especially those where present danger to children's safety has been identified. As outlined in the team's goals for 2012, the Intake Unit Supervisor did complete the Supervisor Safety Decision Making (SSDM) Program, which was a curriculum that spanned four months and specifically addressed Present Danger Threats. The information and training attained through this curriculum was invaluable and the Intake Unit Supervisor was able to share it with the Initial Assessment and Afterhours staff through mentoring, and transfer of learning activities.

Another team goal for 2012 was to ensure that all Initial Assessment and Afterhours staff completed the Stepwise Training, as well as attend any other relevant training that enhance our practice and proficiency. Stepwise is a type of forensic interviewing that employs techniques to minimize any trauma a child may experience during the interview. In addition, the goal is to maximize the amount and quality of the information obtained from the child, minimize any contamination of that information, and maintain the integrity of the investigative process for the agencies involved. The steps in this method begin with the most open, least leading, least suggestive form of questioning and, if necessary, proceed to more specific and more leading questioning. Our Department facilitated this training through the UW Southern Training Partnership and it was attended by both our staff and local law enforcement. Some staff completed the Stepwise Training for the first time in order to become certified in conducting this interview protocol, while other staff members attended it for the second time in order to fortify their skills. Being trained and skilled in the Stepwise Interview protocol is essential when conducting forensic interviews with children, especially in cases of in-home sexual abuse. The Intake Unit staff also attended various trainings throughout 2012, which included trainings that focused on child safety, effects of child maltreatment, impact of substance abuse on children and families, engagement skills, as well as ethics and boundaries training.

It has always been one of the Department's main objectives to maintain children in their homes; however, when this is not possible and out-of-home placements are necessary in order to ensure safety, efforts are focused on placing children with safe and appropriate relatives. Making such diligent efforts is not only best practice, but it is also dictated in the Wisconsin Ongoing CPS Standards, as well as by 2009 Wisconsin Act 79. Starting in April 2012, efforts to maintain children in their homes were further supported by an In-home Safety Services Initiative Grant that Jefferson County was awarded by the Departmet of Children and Families. Together with Green and Rock Counties, and Orion Family Services, Inc. the consortium creates and implements in-home safety plans that keep children safely in their homes. Components of the In-home Safety Services Initiative include concentrated safety monitoring through home visits and phone calls, interventions such as parenting classes, a 24/7 crisis response hotline, volunteers and informal supports to families, and connection to resources.

As illustrated on the graph for Screened In Child Abuse and Neglect Reports on the following page, the number of reports for investigation each year has steadily increased since 2009. Of these, allegations of Neglect are the most commonly investigated type of child maltreatment. There has been a notable shift in the type of neglect being investigated. Over the past few years there has been a significant increase in cases involving alcohol and drug abuse by parents with substance abuse issues that negatively impacted their ability to care for their children. Of these cases, many have involved infants that are born drug-affected due to the mother's abuse of drugs during pregnancy. This is a troublesome trend that is occurring statewide. Our Agency works collaboratively with law enforcement, treatment providers, and the court system to respond proactively through intervention and services.

Screened In Child Abuse and Neglect Reports	2009	2010	2011	2012
Physical Abuse	76	92	100	104
Neglect	96	90	135	123
Sexual Abuse	65	55	58	59
Emotional	0	2	5	9



In addition to conducting CPS investigations, the Intake Unit continues to conduct Child Welfare Assessments on referrals where there are identified concerns for children and families but there are no allegations of maltreatment or child danger threats have been identified to warrant a CPS intervention. The goal of Child Welfare Assessments is to provide preemptive intervention and services to families so that the identified concerns can be addressed and not escalate to a need for CPS intervention.

The Intake Unit also continues to be responsible for processing Juvenile Justice and Truancy Referrals. These Referrals come from local law enforcement and school personnel. After a referral is received, a meeting with the juvenile and his or her family is held to discuss the referral, social information on the juvenile and family is gathered, a case disposition is discussed, and the Juvenile Delinquency Risk Assessment is completed. The Juvenile Court Intake Workers then forward these cases onto the District Attorney's Office with their recommendations. Recommendations can include dismissal of a case, filing of a Deferred Prosecution Agreement, or filing of a Delinquency Petition which initiates formal court action. When a juvenile is placed on a Deferred Prosecution Agreement or a formal Court Order, the case is transitioned to the Juvenile Justice Integrated Services Team for ongoing case management. As shown on the graphs regarding Juvenile Referrals, there were 187 delinquency referrals processed in 2012 which is a 20% reduction in referrals since 2008 with 48% being the juvenile's first referral. Also noteworthy is the reduction in certain offenses over the past five years. As shown on the Juvenile Crimes of Greatest Concern graph, since 2008 referrals for Burglary have gone down by 51% and Sex Offense crimes have decreased by 49%. This data illustrates that early intervention and services for delinquent youth can reduce recidivism.

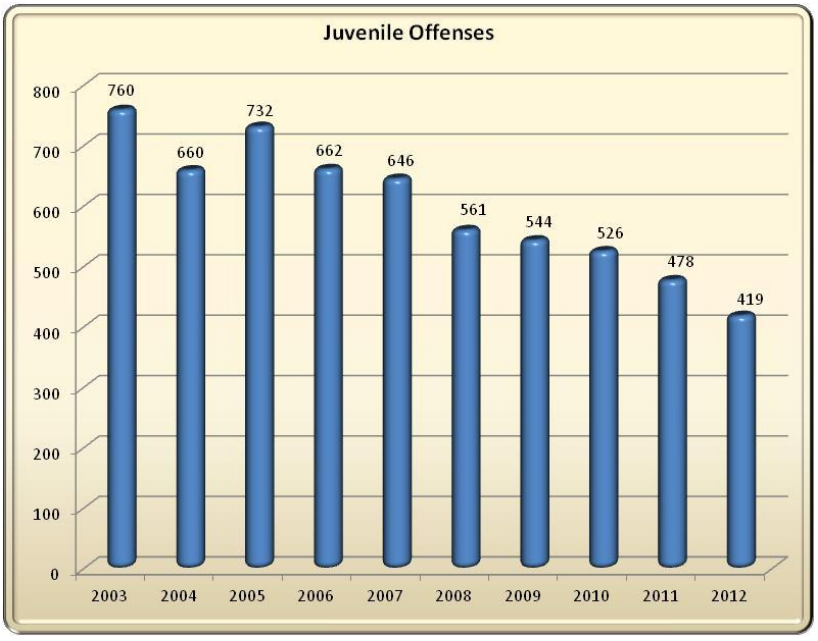
JUVENILE CRIMES OF GREATEST CONCERN 2008-2012

OFFENSES	2008	2009	2010	2011	2012
Arson	3	7	0	0	1
Battery	42	28	33	31	35
Burglary	18	50	35	43	18
Crimes Against Children/Other	16	15	24	12	7
Drug Related	71	51	55	44	54
OMVWOC/Other Vehicle	22	5	15	5	10
Sex Offense	57	20	44	42	21
Truancy	34	30	37	31	24
Weapon Related	13	19	4	12	6
TOTALS	**276**	**225**	**247**	**220**	**176**

As reflected on the chart & graph below, juvenile justice offenses show that there has been a steady decline in the number of referrals made since 2005. There was a 9% decrease between 2011 and 2012. One of the main goals of the Intake Unit and the Juvenile Justice Integrated Services team has always been to reduce recidivism through a balanced and restorative approach that makes the victim, offender, and community whole again. It is believed that this goal is steadily being achieved as the number of juvenile justice referrals decline.

Juvenile Offenses

2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
760	660	732	662	646	561	544	526	478	419



REVIEW OF 2012 GOALS

1. Reduce truancy referrals and subsequent formal court action by collaborating with families and schools during the referral process in order to focus on solutions that address underlying issues and prevent court intervention. As of 2012, one of our Juvenile Court Intake Worker's has been designated to handle all of the truancy referrals and she is committed to accomplishing this goal. At the commencement of the 2012-2013 academic year, letters were sent to all of the schools in Jefferson County by our Juvenile Court Intake Worker. The letter outlined our intent to promote collaboration between our Department and school personnel so we, as a multi-agency team, can put into action school-based solutions that address underlying truancy factors. We have found that there are a broad range of circumstances that can contribute to truancy, such as a family's lack of transportation resources or students suffering from mental health issues. It is the hope that various ways of addressing truancy can be developed, and prevent the need to place youth on truancy court orders. As shown on the following graph, there were 24 truancy referrals received in 2012 which is a 27% reduction in truancy referrals since 2008 – Chart of Juvenile Crimes.

2. Review the Risk Assessment Tool currently being used and enhance its use. However, the Wisconsin Division of Juvenile Corrections is proposing that Wisconsin counties use the risk assessment and case planning tool, COMPAS. We will focus our efforts on implementing COMPAS as our delinquency risk assessment tool.

3. Maintaining compliance with all CPS and Juvenile Justice State and Federal Standards and timelines is always a goal for the Intake Unit and continues to be a primary objective for us. We are accomplishing this goal and the Intake Unit takes a great deal of pride in this, especially given the increasing caseloads and casework demands. In 2012, the Intake Unit was in 99.2% compliance with completion of CPS Initial Assessments within the designated 60 day timeline, whereas the average statewide was 66.85% In addition to this, the Intake Unit was in 86.6% compliance with successfully making initial face-to-face contact with families on CPS cases within the designated response time, while the average statewide was 77.75%. The Intake Unit makes every effort to successfully make initial face-to-face contact with families within the designated response time. Various factors can hinder this however, including a family's unwillingness to cooperate with the Initial Assessment process, refusal to make themselves available to meet, and moving out of the county.

The Intake Unit is proud of what we accomplished in 2012 and we continually strive to be trailblazers in providing services and intervention to children, youth, and families.

2013 GOALS

1. Become proficient in the implementation of Alternative Response cases and use this approach in every CPS case that allows for this investigative approach.

2. Continue to identify and utilize appropriate relatives and collateral contacts on CPS cases in order to aid in completing thorough family assessments, as well as connect families with supports and services.

3. Maintain proficiency in the use of protective plans when present danger threats are identified in CPS cases and ensure that they are sufficient, feasible, and dependable.

4. Continue to maintain compliance with all CPS and Juvenile Justice State and Federal Standards and timelines.

5. Evaluate the use of more Evidence Based Practices in Juvenile Justice and increase knowledge and practice on mental health issues and how they can relate to delinquency and truancy.

6. Continue to develop and strengthen collaboration with our community partners and multi-disciplinary teams in order to support and serve our children, youth, and families in Jefferson County.

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CHILDREN IN NEED OF PROTECTION AND SERVICES (CHIPS)

~Empowering families to achieve permanency for the children through collaboration and partnership with the Circuit Courts, individual families, contracted & agency providers, and community resources~

Child Abuse is a major concern and precursor to many life problems. We receive child abuse reports from members of the public, including neighbors, relatives and friends of families where abuse or neglect is a concern or potential concern. A large number of reports are also received from schools, police departments, physicians and other service providers or professionals. Each report is handled according to the state legal requirements for child abuse investigation and child protection. Once a report is made, our Intake staff handle the investigations through the court disposition.

Child abuse records in Wisconsin are registered and tracked in a computer based system known as WISACWIS, (Wisconsin Automated Child Welfare Information System). This system provides a very detailed computerized system for documenting and reporting child welfare referrals and providing on-going services, including out of home placements. In addition to this, due to Federal Audits of Wisconsin's Child Welfare System, there is additional training, practice and recording requirements for Wisconsin Counties. More time is now required on a per case basis to perform the necessary work and to produce the required documentation. Our workers are required to constantly make judgments that deeply affect the lives of children and their families. These decisions can include removing children from their homes in cases of severe danger, and requesting intervention of the Court. While other cases can involve no action on our part at all, both types of decisions carry potential benefits and consequences for families and for the Department. Once a dispositional finding is made, the Children in Need of Protection Services (CHIPS) team becomes involved via formal case transfer. In 2012, the CHIPS and Intake teams continued to refine the case transfer policy as a means of clearly defining worker roles, decreasing safety concerns, and following DCF standards.

The Children in Need of Protection and Services (CHIPS) Team is comprised of a supervisor, eight ongoing Case Managers, one Family Development Worker, and one Foster Care Coordinator. These workers are responsible for monitoring the ongoing CHIPS orders, and forming collaborative plans with families to meet both the elements of the court order and the family's goals.

Once the case is transferred to the CHIPS Team, an ongoing Case Manager is assigned and a treatment plan for the child(ren) and parents is developed. Each case is unique with overriding factors such as poverty, domestic abuse, unmet mental health treatment needs, failure to thrive, reactive attachment disorder, chronic homelessness, criminal charges and sentences, and immigration to name a few. The CHIPS Team works closely to address these issues with internal Human Service providers such as Economic Support, Comprehensive Community Services (CCS), Community Support Program (CSP), the Aging and Disability Resource Center (ADRC), the Waiver Program (CLTS), and the Mental Health and Substance Abuse Outpatient Clinics, as well as agency Medical Director Dr. Mel Haggart. The CHIPS Team also works closely with community providers

including area hospitals and clinics, People Against Domestic Abuse (PADA), local law enforcement agencies, the State Public Defenders Office, and private child placement agencies.

The CHIPS Team approaches each case with goals aimed at ensuring the safety of the children involved and at the same time providing for their permanence. Permanency options include: If the children were placed in home at the time of Court disposition, children can remain in home with their parent(s) or guardian. If the children were placed outside the home at the time of disposition, permanency options include reunification with parent(s) or guardian, Ch. 48 Subsidized Guardianship, Ch. 54 Guardianship, and Termination of Parental Rights and Adoption.

In 2012, The Wisconsin Department of Children and Families Division of Safety and Permanence Administrator Fredi-Ellen Bove highlighted three key Permanency Initiatives. The first was the release of long awaited and much anticipated Ongoing Standards revision. This all-encompassing manual guides practice for all ongoing case managers in the State of Wisconsin. Secondly, Wisconsin will continue to implement Permanency Roundtables with a comprehensive roll-out plan with a goal of all counties being on board by May 2013. Finally, Wisconsin will continue to recognize Subsidized Guardianship as a permanent placement option for children in out-of-home care. Unlike adoption, Subsidized Guardianship transfers legal authority to a guardian without terminating parental rights. The Jefferson County Human Services CHIPS team implemented initiatives in 2012.

The Wisconsin Department of Children and Families released the Ongoing Standards in early November 2012. The new standards implement new provisions of 2011 Wisconsin Act 181: Best Outcomes for Children. Key provisions of this act contained in the new Standards include Trial Reunification, concurrent planning, and Use of Other Permanent Living Arrangements (OPPLA). The CHIPS team supervisor and ongoing case managers use the new Ongoing Standards regularly at team meetings, during supervision, and as a part of everyday casework. Additionally, the CHIPS team supervisor took part in a two day Ongoing Standards Pilot training as a means of becoming more familiar with the Ongoing Standards.

In anticipation of the Ongoing Standards release in November 2012, the CHIPS team made regular use of Trial reunification on appropriate cases. Trial Reunification enables a child in out-of-home care to be placed in the home of a parent or other relative caregiver for a specified period of time for the purpose of determining the appropriateness of reunification. This provision allows the case manager greater latitude in ending the placement if it is deemed unsafe or to the detriment of the child. This provision further dictates that the county hold open the previous placement for a less traumatic change in placement back to the previous provider should a safety issue arise. Finally, this provision directly addresses the possibility of placement re-entry on a given case given that the status of the child remains out-of-home until the trial reunification period ends and this provision time period does not count against Federal law timelines. The mindset behind this provision has proved valuable on several cases already and both the Jefferson County Circuit Courts and Jefferson County District Attorney's Office often suggest and make use of this provision on a regular basis.

Another provision of the newly released Ongoing Standards is the use of concurrent planning. Per the Ongoing Standards, case managers are expected to file a Permanency Plan with the courts not more than 60 days after the start of an out-of-home placement. The assigned case manager must identify a primary permanence goal amongst recognized goals such as reunification, guardianship, or termination of parental rights. The new Ongoing Standards clarify the implementation of a second or concurrent goal. Concurrent planning clarifies that child welfare agencies when appropriate must work towards multiple permanency goals instead of focusing on one goal at a time and clarifies the court process and role in concurrent planning. The CHIPS team now regularly screens cases for concurrent planning using Ongoing Standards provided tools to measure the appropriateness of concurrent planning. This provision provides case managers and families with options in terms of case planning, goal identification, and service implementation.

In 2012, the CHIPS team continued to take part in the Permanency Roundtable series. A Permanency Roundtable (PRT), is an intervention designed to facilitate the permanency planning process by identifying realistic solutions to permanency obstacles for children. The PRT protocol invites key players such as State Permanency Consultants, Policy Experts, External Consultants, trained Facilitators, case managers, and the team Supervisor to take part in a formalized, prescribed case consultation process. The process is initiated by a formal case presentation by the assigned case manager. The team is then allowed to ask questions of the case manager and supervisor as a means of clarification. This is followed by a brainstorming session whereby any and all ideas are welcomed. The case manager is then allowed to choose new avenues to explore in terms of achieving permanency for the cases being reviewed. Finally, the permanency outcomes for all of the children are rated on a continuum from poor, uncertain, fair, good, very good to permanency achieved. In 2012, the Jefferson County CHIPS team hosted six rounds of PRT's involving nine cases and seventeen children. The CHIPS team chose to present very difficult, long standing or "legacy" cases. All children involved on these cases were rated to have a "poor" outcome at the beginning of 2012. At the close of 2012, one child had achieved permanency through reunification with a parent. Six more children had their status improve to "good" and five more children were moved to pre-adoptive placements resulting in a "fair" or "uncertain" status finding. At the close of 2012, five children still had a rating of "poor". These cases will continue to be presented at upcoming PRT's or until their status is improved.

In 2012, The CHIPS team continued to utilize the Subsidized Guardianship program as highlighted in 2011 Wisconsin Act 181: Best Outcomes for Children. The implementation of the Subsidized Guardianship program is now clearly defined in the Ongoing Standards and in 2012 the CHIPS team successfully petitioned the Jefferson County Circuit Courts on behalf of two more children. There were also three pending petitions filed with the court at the very end of 2012 with court dates scheduled for early 2013.

In 2012, when fully staffed, the eight ongoing Case Managers carried an average of 11.9 cases or about one less case per worker than in 2011. The average caseload for the year included responsibility for an average of 7.0 children placed in home and 12.9 children placed outside the home. Both of those numbers are down slightly from last year.

Part of work, unfortunately, involves removing children from their home when serious abuse and/or neglect has occurred. To assist in providing more timely permanence for children, the Department entered into a state contract, allowing us to retain legal counsel to represent the Department in Termination of Parental Rights (TPR) court proceedings. At this time, a number of children are unable to be reunited with their families for a variety of reasons. The Department will consider every possibility, including guardianship, before requesting a Termination of Parental Rights. This CHIPS team continues to focus on meeting court ordered permanence goals with every family we serve. In 2012, the Department petitioned Jefferson County Circuit Courts to terminate the rights for children on two cases involving 5 children including one Safehaven baby. These children found permanency with an adoptive resource. In 2013, the Department has assigned five cases involving a total of fifteen children to the special prosecutor for the petitioning of Termination of Parental Rights. At the same time, the Department has set up a series of very comprehensive trainings with community stakeholders such as the Jefferson County District Attorney's Office, the public bar, and State Public Defenders Office in order to form a more cohesive and agreed upon track of legal preparation for potential Termination of Parental rights cases.

REVIEW OF 2012 GOALS

1. Continue to enhance Ongoing Case Management staff knowledge and skills through ongoing education in collaboration with the Southern Partnership, community partners, and individual workshops.
All staff attended the new Confirming Safe Environment as well as the Safety Booster trainings through the Southern Partnership. Other team members attended many trainings through the Southern Partnership for a total of over 300 hours of training.

2. Continue ongoing training with the Child and Adolescent Strength and Needs Assessment (CANS) tool. Implement yearly recertification schedule for all staff and use tool to better match the needs of children in placement with providers. Engage providers directly in the CANS rating process.
All staff were recertified to use the CANS assessment tool. In addition, all staff were instructed to use the tool directly with caretakers whenever possible. This directive was part of a State mandate.

3. All Ongoing Case Management staff shall complete Safety Foundation training to become aware of changes made to the Safety Threshold Criteria. This training will ensure compliance with ongoing safety standards.
All staff have completed Safety Foundation through the Southern Partnership. In addition, all current family development staff have completed Safety Foundation.

4. Use CHIPS team meeting to have regularly scheduled informational sessions to facilitate transfer of learning. For 2012, schedule trainings related to co-sleeping, PADA collaboration, and document production have been scheduled.
The CHIPS Team meets regularly every Monday for a period of three hours (9:00 a.m. - 12:00 p.m.) to staff and assign cases, discuss policy and procedure, and to experience transfer of learning. In 2012, the team welcomed a team of State Permanency Consultants, Comprehensive Community Services staff, members of the JCHSD Mental Health Team, as well as CLTS/Waiver team members.

5. All ongoing staff shall complete an interactive RAD (Reactive Attachment Disorder) training or seminar.
The Children and Families Division partnered with the Comprehensive Community Services supervisor to host a one day seminar focusing on Reactive Attachment Disorder. All CHIPS staff attended along with personnel from various community partners.

6. Continue to engage in the State of Wisconsin Permanency Roundtable (PRT) series as part of a consortium with Rock and Green counties. Schedule nine cases for review by the end of 2012.
The CHIPS team hosted six rounds of permanency roundtables involving nine cases with seventeen children. The projected permanency for all seventeen children was termed as "poor" during the first round for each child. At the close of 2012, the permanency status for nine of the children had improved to "uncertain" and to "fair" or "good" for another six children.

2013 GOALS

1. Continue to use the Permanency Roundtable model as a tool to help the children of Jefferson County achieve permanency. Host three rounds of Permanency Roundtable consultations introducing six new cases. This can be measured through eWiSACWIS case tab query.

2. Increase CHIPS team and worker support by having each worker complete a secondary trauma training. This can be measured via certificate of completion.

3. Enhance the use of In-Home Safety Planning in collaboration with The Southern Partnership, DCF Standards, and Orion Safety Services. Achievement of this goal will directly decrease out of home placements. This goal

can be measured through certificate of course completion, transfer of learning, increased use of in-home safety plans, increased referrals to Orian safety services coaching, and mentoring during regular case staffings.

4. In conjunction with the Ongoing Standards release by DCF in November of 2012, produce job aids and placards in order to assure compliance with the standards in the areas of Confirming Safe Environments (CSE's), documentation of home visits, and the production of Permanency Plans. This goal can be measured during supervisor consultation, coaching, and mentoring.

5. Complete a two part series of Effective Legal Case Preparation with special prosecutor Henry Plum. This goal can be measured via certificate of completion and through worker/ supervisor consultation.

6. Increase Out-of-Home monthly case worker contact compliance to 95%. This goal can be measured via eWiSACWIS summary reports.

7. Screen every out-of-home case for concurrent planning at the six and twelve month mark or prior to any agency or judicial review. This can be measured through staffing documentation.

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JUVENILE JUSTICE INTEGRATED SERVICES

~Understanding that our youth come to us with deep hurts, and looking at both the strengths and needs that each one of our kids has, hoping that they will feel encouraged and supported to achieve success~

The Juvenile Justice Integrated Services Team provides ongoing case management for youth on Juvenile Delinquency, Juvenile in Need of Protection or Services (JIPS), Consent Decree, Chapter 51 Orders, Deferred Prosecution Agreements and voluntary cases. The Juvenile Justice Team recognizes the dignity of each and every youth. We offer trauma informed care, are treatment focused and work with youth and their families to develop natural strengths and supports to enhance the positive, prosocial qualities of our youth. Our team seeks to meet the unique needs of youth while assuring a safer society. We identify risk factors early on to be effective in preventing juvenile delinquency and future criminal behavior. Some risk factors include: lack of education, learning disabilities, developmental disabilities, mental illness, emotional/behavioral disabilities, poverty, domestic violence, and all forms of abuse and neglect. We understand the importance of working with youth, their families, and their support systems to enhance and encourage success. The Juvenile Justice team is comprised of the Division Manager, Juvenile Justice Supervisor, five Case Managers and two Intensive Supervision Workers.

The youth served by the Jefferson County Juvenile Justice Team come with multiple strengths and needs. It seems as if these children are coming to us with more complex needs than ever before. According to information obtained on the Federal Substance Abuse Mental Health Services (SAMHSA) website, "studies have found that 60-70 percent of youth in the juvenile justice system met criteria for a mental disorder; over 60 percent of these youth also met criteria for a substance use disorder. Of those youth with mental and substance disorders, almost 30 percent experienced disorders so severe that their ability to function was highly impaired." Many of the youth that are in the juvenile justice system of Jefferson County have been diagnosed mental health disorders. Several carry trauma with them, which can lead to emotion dysregulation, alcohol and/or drug use, poor impulse control, poor social skills and antisocial behaviors.

JUVENILES WITH DIAGNOSED MENTAL HEALTH DISORDERS

February 2012	**53 out of 106.5 juveniles**	**50 percent of total juveniles**
June 2012	**56 out of 99 juveniles**	**57 percent of total juveniles**
October 2012	**63 out of 94 juveniles**	**67 percent of total juveniles**

When youth leave the courtroom and walk through our doors they need us to have a comprehensive understanding of why they are who they are, why they did what they did, and what can help them to heal. In 2012 the Juvenile Justice Integrated Services Team found an even greater need for resources for our juveniles that entered our doors. Though the total numbers of referrals was down by 22 percent from the previous year, the team saw an increase in juveniles with mental health issues and serious alcohol and drug concerns. The number of youth with diagnosed mental health disorders rose throughout the year, and the numbers of youth with alcohol and/or drug issues rose from last year.

Concerned and exasperated parents look to us to find the answer to these complex needs, as outside resources can be limited in smaller communities. In order to provide the necessary services, the team has increased their collaboration with both internal resources, such as Wraparound and Comprehensive Community Services programs, and has formed a committee to design a plan to offer more targeted, accessible AODA treatment within the county. We continue to offer in-house services as well, such as Aggression Replacement Training groups for juveniles who need to learn additional anger management tools, Prime for Life AODA education classes and Juvenile Cognitive Intervention Program; all evidenced based models. We remain focused on reducing and preventing placements of our youth (i.e. secure custody and respites) while also ensuring the safety of our community, and these interventions help us to make that possible.

The Intensive Supervision Program continues to strategize and find ways to build on youth's strengths, help them make better choices, and prevent respites/detentions when possible. ISP workers meet with juveniles and families on a daily basis and are instrumental in helping families develop effective crisis management plans and communication. In 2012, 26 youth were served in ISP and out of those, 88 percent remained in the home. One youth was placed in foster care, two youth were removed from the home and placed in a treatment facility and no youth were placed in a juvenile correctional facility. Furthermore, ten youth participated in outpatient therapy, all 26 youth participated in an academic program, 411 hours of community service were completed and $2,562.60 restitution was paid.

Law Enforcement Youth Delinquency Referrals as reflected in the following charts:

- 232 different youth were referred for a total of 419 offenses in 2012. This reflects a decrease in both youth who offend and offenses themselves. Statistics continue to show a pattern of decreasing juvenile delinquent activity. We consider this to be a testament to our collaborative efforts within our agency and with our community partners in utilizing best practice models that support our youth and families, provide treatment and supervision, and reduce recidivism.

- 57 percent of the total of youth referred were 14 or younger.

- 18 percent of youth were referred four or more times and 10 percent were referred six or more times. 2 percent of these youth were referred nine or more times, and all of those youth within that group were 14 or younger. This reflects what case managers are seeing in their practice and also generally indicates the proportion of youth who require our most intensive services in terms of time and costs.

- The total number of offenses and referrals for all youth has decreased, but it is worthy to note that the drug related offenses has risen by 19 percent since last year. Again, this reflects the needs we are seeing as a team in this area and why we are trying to increase the availability of services.

- The occurrence of youth involved in our juvenile justice system who also have a diagnosed mental health disorder rose throughout the year and mirrored the findings of SAMHSA mentioned earlier.

2008-2012 Juvenile Intake by Age

	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Youth
2012	11	33	62	39	38	4	**187**
2011	14	45	70	56	49	5	**239**
2010	13	42	61	50	57	2	**225**
2009	17	23	56	59	67	4	**226**
2008	18	29	91	57	48	1	**244**

2012 MULTIPLE JUVENILE REFERRALS BY AGE

		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Juveniles per # of Arrests	% of Total
Referrals	**1**	5	14	25	22	20	4	**90**	**48%**
	2-3	3	15	26	8	13	0	**65**	**35%**
	4-5	2	3	8	6	3	0	**22**	**12%**
	6-8	0	1	1	3	2	0	**7**	**4%**
	9+	1	0	2	0	0	0	**3**	**2%**
Total Juveniles with Multiple Referrals per Age		**11**	**33**	**62**	**39**	**38**	**4**	**187**	**100%**

POLICE REFERRALS for JUVENILE OFFENSES

1 and 5 Year Comparisons

OFFENSES (2008-2012)	2012	2011	1 Year (2011-2012) Increase/Decrease	2012	2008	5 Years (2008-2012) Increase/Decrease
Alcohol/Tobacco	2	2	0	2	1	1
Arson	1	0	1	1	3	(2)
Battery	35	31	4	35	42	(7)
BurglaryRobbery	18	43	(25)	18	18	0
Burning Materials/Fireworks/Explosives	2	0	2	2	1	1
Contempt of Court/Violation of Court Orders	0	0	0	0	2	(2)
Crimes Against Children/Other	7	12	(5)	7	16	(9)
Criminal Damage to Property	28	36	(8)	28	30	(2)
Criminal Trespass	12	6	6	12	7	5
Disorderly Conduct	110	136	(26)	110	138	(28)
Drug Related	54	44	10	54	71	(17)
Fleeing/Escape	8	0	8	8	8	0
Forgery	0	2	(2)	0	4	(4)
Intimidation/Harrassment	7	2	5	7	5	2
Obstructing/Resisting Arrest	21	12	9	21	30	(9)
OWVWOC/Other Vehicle	10	5	5	10	22	(12)
Receiving Stolen Property	0	2	(2)	0	2	(2)
Reckless Endangerment	6	2	4	6	1	5
Sex Offense	21	42	(21)	21	57	(36)
Theft	47	58	(11)	47	56	(9)
Truancy	24	31	(7)	24	34	(10)
Weapon Related	6	12	(6)	6	13	(7)
TOTALS	419	478	(59)	419	561	(142)

REVIEW OF 2012 GOALS

1. The juvenile system is built upon values of rehabilitation and prevention, and while some other counties and contracted agencies continue to utilize a more punitive probation model, Jefferson County Juvenile Justice Case Managers incorporate targeted case management into their practice, assisting the youth and family to create their own goals that highlight strengths and address their complex needs. Our team understands that our youth come to us with deep hurts and looks at both the strengths and needs that each one of our kids has, with the hope that they will feel encouraged and supported to achieve success. It is because of this core philosophy that we set a goal of changing our name from the Delinquency Team to the Juvenile Justice Integrated Services Team, and it was one of the first things we did in 2012.

2. Tighten up our Targeted Case Management (TCM) billing procedures in an effort to lessen the burden of the Jefferson County taxpayers. Our efforts paid off, and we were able to recoup $24,038.76 of the total of $75,344.50 of case management costs billed to Medical Assistance. Juvenile Justice Targeted Case Management reimburses at 33%, which accounts for the discrepancy in numbers. The Juvenile Justice team feels good about their contributions and will continue to follow the new TCM policy closely, so as to maximize reimbursement for next year.

3. Our team also developed a goal around permanency planning reviews in 2012. To encourage positive agency change in the area of our permanency plan review process, select Juvenile Justice Integrated Services Team members participated in an ad hoc committee of community and agency representatives to evaluate the Permanency Plan administrative review process and make recommendations for improvement. Recommendations regarding changes to this process are being discussed with legal partners, including judicial, District Attorney and private attorneys.

4. To better recognize internal and external stakeholder expectations and understanding of our program, the Juvenile Justice Integrated Services team participated in a formal program evaluation, facilitated by the UW Extension office. Feedback obtained from this study indicated that we needed to provide more outreach, communication and education about what we do to the community, and we have made that a goal for 2013.

5. The population of adolescents with whom we work can be thought of by some as "bad kids with nothing to offer society." However, we are privileged to see another side of these youth and believe that each one of them has something positive to offer. To highlight youth strengths, assets, achievements and positive school and community involvement, the Juvenile Justice Integrated Services Team explored ways to get youth involved in the Juvenile Justice system with the Jefferson County Connections youth committee . Juvenile Justice Team members informed youth of the meetings and offered transportation if it was needed. At least one youth attended a meeting and additional kids participated in the dodge ball events held at the different high schools throughout the county.

6. Utilizing feedback from surveys based on research from the Search Institute regarding the importance of youth asset building, the Juvenile Justice Integrated Services Team has made a commitment to providing meaningful youth activities. The surveys showed that Jefferson County youth who participated in these activities noted improved assets in the areas of support, empowerment, boundaries, commitment to learning, positive identity and social skills. In 2012, the team offered a community service activity cleaning up the Johnson Creek dog park, a trip to the Milwaukee Zoo and one of the most popular activities, "Paint a Pot."

7. In an effort to increase the availability of incentive money for the youth activity fund in 2012, the Juvenile Justice Integrated Services Team explored additional means of funding sources. Different sources of funding were explored, including a Juvenile Justice Commission grant, and the team completed the application for it. Youth asset building is an important goal, and the team will continue to look into increasing the funding for youth activities in 2013.

8. Services supported by research were, in 2012, and continue to be, at the forefront of our programming. To highlight this value, we continued to provide evidence-based service delivery, including, but not limited to, Motivational Interviewing, Juvenile Cognitive Intervention Program, Aggression Replacement Training, Incredible Years, PRIME for Life and Juvenile Drug Court. The Juvenile Justice Integrated Services Team also joined together with the Restorative Justice Team to offer a comprehensive, team-based approach to working with families.

2013 GOALS

This year, the Juvenile Justice Integrated Services Team will focus efforts on creating additional resources to meet the needs of our youth while maintaining the services we currently provide and providing outreach and education to community partners.

1. To better meet the needs of youth and decrease the number of out of home placements, our team will create and increase the treatment resources for juveniles with alcohol and drug issues and sexual offending behaviors by partnering and contracting with targeted providers who will deliver individual and group services to youth in this county.

2. To carry on the value of providing services supported by research, we will continue to provide evidence-based service delivery, including, but not limited to, Motivational Interviewing, Juvenile Cognitive Intervention Program, Aggression Replacement Training, Incredible Years, PRIME for Life, Wellness Recovery Action Planning (WRAP) for youth who battle mental illness, and Seeking Safety groups through an interagency partnership with the Comprehensive Community Services program.

3. To strengthen the communication with community partners and provide more effective crisis planning to our youth and families, our team will establish regular meetings with local police departments to discuss pertinent issues and brainstorm workable plans to best address juveniles with specialized needs.

4. October is national Youth/Juvenile Justice Awareness month. To increase awareness and provide education to community members about juvenile justice prevention, our team will provide additional activities and educational forums in various Jefferson County communities.

5. Many of the youth who are served by the Juvenile Justice team lack opportunities for positive social activities for a number of different reasons. Increasing these opportunities is often noted as an unmet need by the juvenile and parents and is then included in the case plan. To provide opportunities to meet these goals, our team will continue to offer group activities that help children in the areas of self-esteem, social skill building, positive peer interaction and socialization without crime or negative influences. Some of the more popular past activities were spa day, craft and art activities and a trip to the Milwaukee Zoo to kick off a WRAP group.

6. In an effort to increase the availability of incentive money for the youth activity fund, the Juvenile Justice Integrated Services Team will create a fundraising committee to explore additional funding sources, such as local, state and federal grant opportunities, seeking donations from local businesses, and fundraising.

7. The Juvenile Justice Integrated Services Team values the preservation of families and works very hard to provide effective services that will protect the community while allowing juveniles to stay in their homes or with their families. When juveniles do require an out of home placement, our team and the Department as a whole, strives to find permanency for these youth. Though it does not happen often, when parents or relatives do not appear to be an option for permanency, kids can get “stuck.” To maximize and exhaust all possibilities for permanency options, our team will begin the process for getting trained in and eventually will conduct Permanency Round Tables (PRT’s). This has been invaluable to the Child Protective Services team and we believe it is a good direction for us to go as well.

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JUVENILE RESTORATIVE JUSTICE PROGRAMS

~Ensuring that youth are positively restored to their communities~

Jefferson County Human Services contracts with Opportunities Inc. to provide Restorative Justice Program options to youth who have offended to ensure they are positively restored to their communities. Service advancements were put in place in 2012 to enhance youth accountability and improve program outcomes. The new outcome goals were put into place in June of 2012.

The Restorative Justice Programs include:

Teen Court

Community Service

Restitution

Educational Programs

Victim Offender Conferencing

TEEN COURT

Teen Court is a community based program for first time and minor repeat offenders. It offers eligible youth an opportunity to receive a meaningful sentence from a jury of their peers in lieu of appearing in circuit court and paying their citation. Youth who successfully complete the program will have the charge dismissed from their record.

The Jefferson County Teen Court program was established in 1998. In 2012, there were 34 Teen Court participants. Completion statistics are as follows:

	Participants	Percentage
Successful Completion	23	68
Active in the Process	8	24
Unsuccessful Completion	1	3
Chose to Withdraw	2	5

Participants are required to serve on the jury for other peers. The jury determines the sentence which may include options such as apology letters, community service, restitution and various projects or activities. Participant feedback from the Teen Court experience included the following comments.

- *"It taught me a lesson while not being as intimidating as actual court"*
- *"You get a fair punishment"*
- *"While completing community service, I learned that helping someone really does make a difference"*
- *"I would love to do teen court again but would rather not get into more trouble"*

Referral sources for this program include Jefferson County Human Services, Police Departments and Municipal Courts.

Cost-benefit analysis reports completed in the past have concluded that the Teen Court Program affords Jefferson County both financial savings and the rewards of a restorative justice process which are more

challenging to measure. However, it is noteworthy that no referrals were made to this program for a repeat offense in 2012.

COMMUNITY SERVICE

While performing Service to Community, juveniles are being held accountable for their actions while restoring the community in a positive manner. Staff assist youth in planning for and facilitating options to reach their commitment to community service through both supervised site options and activities completed independently.

The Restorative Justice Program of Jefferson County has been providing service to community supervision to youth since 1997. In 2012, the Restorative Justice Team worked with 126 service community participants. During the year, 75 completed their order with 86% successfully fulfilling expectations by completing their community service plan.

Youth performed community service throughout Jefferson County. In 2012, through a program advancement process, the Restorative Justice Team has taken a more creative and individualized approach to planning for service to community referrals. The Restorative Justice Program offered 6 weekly supervised community service sites at a variety of locations for youth to attend across the county. Additionally, the Restorative Justice Program provided participants with 19 community service events throughout the year. Youth participated in recreational activities with the residents of assisted living facilities, helped at various community activities in places like the Health and Wellness Center of Watertown, Bread and Roses, the Fort Atkinson Food Pantry and Head Start in Watertown and during community events like Lights and Sirens in Watertown, the Boys and Girls Club Wings and Wheels event, Fort Atkinson's half marathon, and the Literacy Council's Ride the Rock. Feedback requested from service to community supervised sites was positive with comments such as:

- *"Great interaction with our residents. They see a younger crowd come in and they like the energy of the kids."*
- *"It is great to have extra help with the things that always need to be done"*
- *"It helps with set-up since many adult volunteers cannot be here until after 4 p.m."*

REVIEW OF 2012 GOALS

1. 85% of all Community Service cases closed in 2012 will successfully complete their community service order.
    - Outcome: 86% completed

2. Opportunities, Inc. will develop four additional community service events in 2012.
    - Outcome: 19 community service events occurred.

RESTITUTION

The Restitution Program facilitates planning and implementation with youth, to help ensure victims are compensated for monetary damage.

The restitution monitoring component of the Restorative Justice Program has been in place since 1996. In 2012, the Restorative Justice Team assisted 50 participants in meeting their restitution obligations. Based on new referrals for 2012, two-thirds of all the participants of the Restitution program are categorized as ineligible for work, meaning they are 15 years of age or younger. Another 42% were ineligible for work but

made an initial payment towards meeting their obligations. (These cases are still open). During 2012, 26 participants completed their order with 73% successfully paying victims back for monetary damage.

Through a service advancement process completed in 2012, the Restorative Justice Specialists are now assisting participants in locating jobs. Opportunities, Inc. is also providing work options for participants 16 years of age or older.

In 2012, nearly $10,000 in restitution was collected and repaid to the victims of crimes in an effort to compensate them for monetary damages. Feedback from victims included the following comments:

- *"I think it's awesome for the follow through"*
- *"Not as quickly as thought but within a reasonable time frame"*
- *"Thanks for your cooperation and concerns"*
- *"The process was completely adequate for me"*

REVIEW OF 2012 GOALS

1. 85% of all Restitution cases eligible for work in 2012 will successfully complete their restitution order making the victim whole.
    a. Outcome: 100%

2. 75% of youth ineligible for work will have family pay toward restitution with youth providing a specific meaningful contribution to reimburse the family.
    a. Outcome: 83%

3. Opportunities, Inc. will develop individual job options for 12 youth in 2012.
    a. Outcome: Eleven were assisted with job development, and 5 job options developed.

EDUCATIONAL PROGRAMS

First Offender Program

Using the evidenced based Aggression Replacement Training (ART) curriculum, this class teaches three main components that include Skill Streaming, Anger Management, and Moral Reasoning. Skills include but are not limited to: Beginning Social Skills, Advanced Social Skills, Skills for dealing with feelings, Skill Alternatives to Aggression, Skills for Dealing with Stress, and Planning Skills. Students also participate in moral reasoning discussion scenarios where students learn appropriate/mature ways of handling tough situations. Each class session is chosen specifically for the current participants, resulting in the class targeting certain learning skills that each participant can benefit from. The majority of the class time is devoted to role-playing, helping to keep the youth fully engaged. In 2012, 13 youth were signed up for the First Offender Program. Nine youth successfully completed the class (69%) and four continued programming into 2013.

REVIEW OF 2012 GOALS

1. 70% of successful participants of the First Offenders program will not re-offend in the following 9 months.

2. No data available yet – goal put in place in June 2012.

Pre-Expulsion Program

The Fort Atkinson and Lake Mills School districts have collaborated with the Restorative Justice Program to provide services to youth who commit alcohol and drug related offenses on school grounds. By providing this alternative to expulsion, youth are given a chance to make amends for their actions and learn about the dangers of drug and alcohol use. The youth referred are required to complete up to 30 service-to-community hours and participate in the ATODA Awareness class. The sanctions are given, in addition to other stipulations delegated by the school district, in an effort to promote substance abuse cessation and encourage youth to get help for any substance abuse issues. In 2012, 8 school districts in Jefferson County are partnering with Restorative Justice Program to offer the Pre-Expulsion Program in their schools.

VICTIM OFFENDER CONFERENCING

The Victim Offender Conferencing (VOC) program gives victims the opportunity to meet face to face with the youth to discuss the crime and why it happened. VOC has been available in Jefferson County since 1997 and the Restorative Justice Team continues to educate and attempt to engage victims in this process. VOC not only benefits the victim but is also restorative for the youth offender and the community as a whole.

The victim benefits from the meditation by being provided a chance to express their feelings about the event at hand, thus allowing the victim a voice. The youth benefits from the mediation by being provided an opportunity to understand and make amends for the damage caused to the victim and/or the community at large. Finally, the community benefits from the mediation by repairing the harm done to the relationships affected by promoting nonviolent forms of conflict management, and potentially preventing the juvenile from offending again.

In 2012, VOC was modified to make it more accessible and increase utilization. The intent of this modification is to ensure juvenile offenders have the opportunity to reflect on how their action affected others. The options for incorporating the concepts of the Victim Offender Conferencing program are:

- Using VOC as a diversion program.
- Incorporating VOC as a component of a Restorative Justice Plan.
- Requiring the youth to write an apology letter to the victim.

REVIEW OF 2012 GOALS

1. The Restorative Justice Program will provide at least 6 Victim Offender Mediation and/or apology letter sessions in 2012
    a. Outcome: Three referrals were made to the program between June and December 2012. One withdrew from the program and the other two cases are still active.

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COORDINATED SERVICE TEAM
(*WRAPAROUND)*

~Keeping children with social, emotional, mental health and cognitive needs in their home~

Per the State of Wisconsin, the Coordinated Service Team initiative is:

A voluntary team approach that exists to keep children with multiple needs in their home and community through the creation and maintenance of a comprehensive, coordinated, and community based system of care centered on strengthening the child and family. The children, youth and families who receive wraparound services are typically involved with two or more child and family–serving systems, such as behavioral health, special education, developmental disabilities, child welfare or juvenile justice. Other organizations and agencies-including provider agencies and community organizations - may also be involved. Both research and experience has shown that successfully implementing the Wraparound Initiative at the team level requires extensive support and collaboration among these various agencies and organizations.

REVIEW OF 2012 GOALS

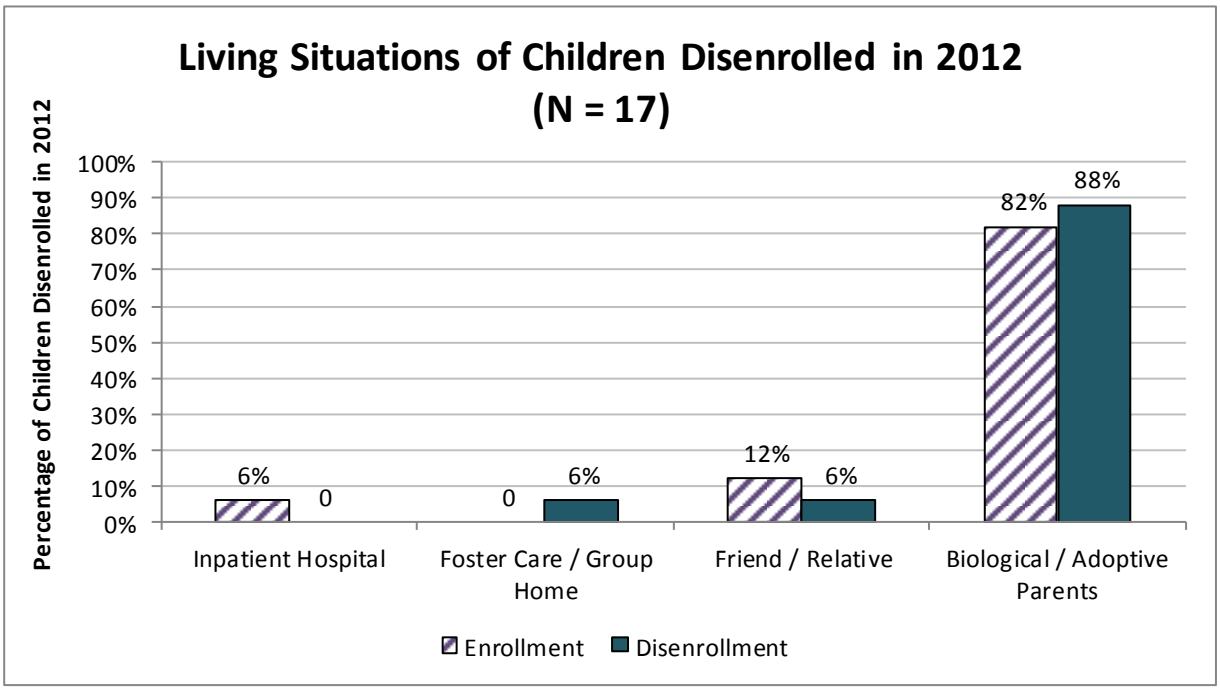
The Jefferson County Coordinated Service Team (CST) reported outcome data to the State Division of Mental Health and Substance Abuse Services (DMHSAS) for 34 children in calendar year 2012. These children were 56% male and 44% female; 77% White, 12% Latino, 9% African-American, and 3% Multiracial. Their ages ranged from 3-18, with an average age of 11.5 years old.

Seventeen of the 34 children served in 2012 were also disenrolled in 2012. Outcomes for these 17 children will be presented in this report. This report compares the initial status at enrollment with the final status at disenrollment on living situations, juvenile offenses, school performance and behavior for children who have been disenrolled. The average length of enrollment in CST for these children was just under one year (11.06 months).

1. LIVING SITUATIONS

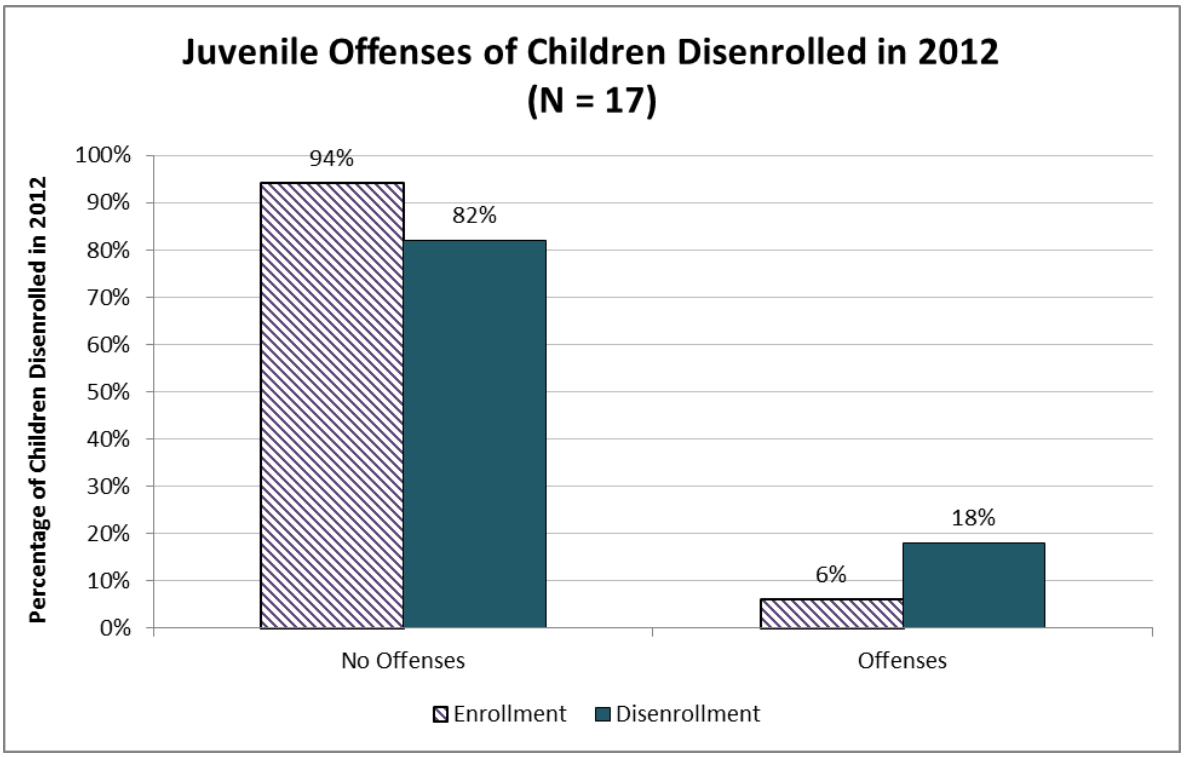
When they were enrolled into the CST Initiative, 14 of the 17 children (82%) were living with their biological or adoptive parents. All of these children were also living with their biological or adoptive parents at disenrollment. Of the two children (12%) living in the home a friend or relative at enrollment, one (6%) had transitioned to living with their biological or adoptive parents by the time of disenrollment. One child (6%) living in an inpatient hospital setting at enrollment had transitioned to regular foster care by the time of their disenrollment.

2012 Goal Accomplished - Maintain children in their biological, relative or adoptive homes
Through team facilitation, we strive to maintain children in their biological, relative or adoptive home by providing services and resources needed by the child and the child's family through the coordinated services plan.



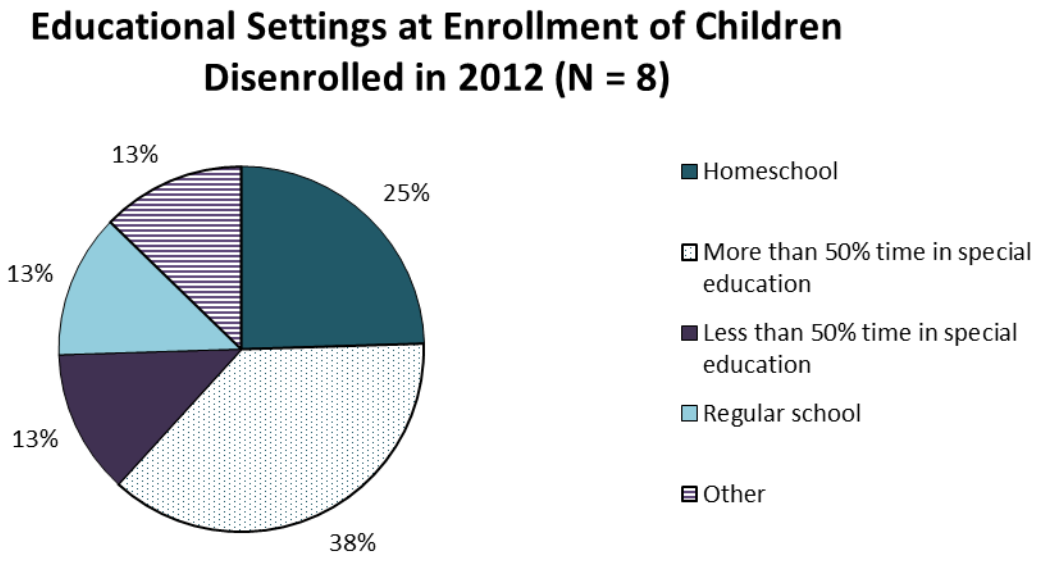
2. JUVENILE OFFENSES

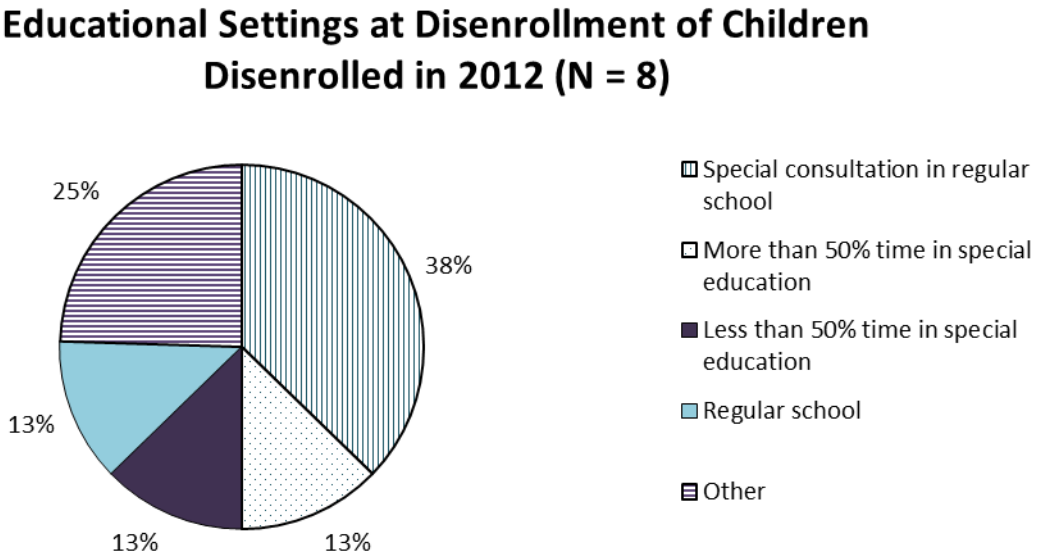
Of the 17 children who were disenrolled in 2012, only three children total committed offenses while enrolled in the CST Initiative as reported to our data entry system, while the other 14 did not. One child (6%) committed an offense in the two months before enrollment, and this child committed offenses while enrolled as well. Two additional children also committed offenses while enrolled (making a total of 18% committing offenses during enrollment in CST).



3. ACADEMIC ACHIEVEMENT AND SCHOOL SETTING

Of the 17 children who were disenrolled in 2012, four had data provided on grades and were enrolled for at least two school semesters. All four children either improved their grades while enrolled in CST, or maintained grades that were a C average or above. No expulsions from school were reported for children disenrolled from CST in 2012. Of the 17 children who were disenrolled in 2012, eight had data provided on school setting and were enrolled for at least two school semesters. At enrollment, 2 (25%) were home schooled, 3 (38%) were in regular school with more than half their time in special education, 1 (13%) was in regular school with less than half their time in special education, 1 (13%) was in a regular school setting, and 1 (13%) was reported as in another school setting (other). At disenrollment, none were home schooled, 1 (13%) was in regular school with more than half their time in special education, 1 (13%) was in regular school with less than half their time in special education, 1 (13%) was in a regular school setting, 3 (38%) were in regular school with special consultation, and 2 (25%) were reported as in another school setting (other).





REVIEW OF 2012 GOALS

1. Service Facilitation

2012 Goal Accomplished - Provide family support for the prevention of abuse and neglect.
Through team facilitation Wraparound will provide community-based services designed to promote the safety and wellbeing of children and families by preventing abuse or neglect from occurring 100% of the time. During the 2012 reporting year there were zero substantiations of Abuse or neglect for the families enrolled in the Wraparound Program.

Thirty four families received support services assessing and promoting safety for the wellbeing of the child and family. Through teaming we provided support to 118 family members (including grandparents, aunts, uncles and siblings).

2. Maintain children in their biological, relative or adoptive homes

2012 Goal Accomplished-Through team facilitation and comprehensive planning, we were able to maintain all enrolled children with their family through implementing the following services. Through the teaming process the following services were implemented allowing the family to become a cohesive family unit. The use of natural supports or Jefferson County's Community Outreach worker allowing the family to have a short term respite, recommending individual or family therapy and assisting the family through the process, getting youth involved in after school events whether they be academic or sports related, weekly team meetings either in the home or the school environment, getting youth involved in their home community. Facilitators advocate for families and educate providers that the least traumatic experience for the child is to maintain them in their biological, relative or adoptive home.

3. Community Outreach

2012 Goal Accomplished - Build and maintain positive outcomes for youth.
Build and maintain positive outcomes for youth through community outreach by conducting school visits and providing activities through community integration suspensions will show a decrease of 75% from enrollment to the end of the year reporting. Grade averages (passing classes) will improve by 75% from enrollment to the end of year reporting

Through community outreach and collaborative team practice we eliminate obstacles to service access and have all participants working together to establish one plan. Jefferson County schools and law enforcement are active community participants.

Through our involvement, schools have identified a decrease in problematic social behaviors as evidenced by police contacts to the school, referrals to the Jefferson County Human Services Intake Department and the accomplishment of team goals documented on the plan. Schools stated that having outreach provided in the schools has decreased problematic social behavior. The Outreach worker can respond to the school if the child is in crisis minimizing the need to contact law enforcement.

Through community outreach services 24 youth received the service through the following contacts:
School Visits – 371
Home Visits – 78
Community Activities – 609
Total amount of contacts made - 1831

Wraparound Initiative NIATx Project:
As a team we identified the need to improve sustainability through billing targeted case management. The change team was made up of the following member's; divisional manager, fiscal department, financial intake, service coordinators, and community outreach workers. Our change project title was Success and Sustainability. Our Aim Statement was to meet targeted case management time lines of assessment and planning to increase collections by 20%. Tools were developed and implemented in May of 2012. Collections have exceeded the 20% target aim.

2013 GOALS

1. Develop a training manual for educating new employees internally and externally. Employees will be asked to participate in a one day training specific to Jefferson County's Wraparound Initiative outlining the different phases and components of each phase of the process.

2. Continue meeting billing criteria deadlines for targeted case management for sustainably to increase revenue costs by 75%. Continue using the internal auditing protocol developed in 2012 for maintaining sustainability of the Initiative.

3. Plan and implement a Family Enrichment day for families to come together with the same experiences to support each other and learn about advocating for their child through the various systems.

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SUPPORTED EMPLOYMENT TRANSITIONS PROGRAM

~Helping high school special needs students achieve their dreams~

The **"Transitions"** program is an employment program for high school students with special needs wanting employment opportunities. This program gives the student the needed support for developing job skills through the support of a job coach. Students were chosen for the program through school personnel. Students were interviewed and asked where they would like to work. After the interview process the program coordinator sought out possible employment opportunities.

The following businesses took part in the program, Piggly Wiggly, Jefferson Area Business Center, Wal-Mart, Funky Hair Design and the Bee Hive. Students worked on a part time basis following all of the hiring policies that the employer requested.

Age	# of Participants
15	1
16	3
17	2
18	2
20	1

Target Population	
Mild Cognitive	5
Severe Cognitive	1
Learning Disability	2
Mental Health	1

Students Employed	
Employed	7
Moved out of the county	1
Looking for new employment	1

Through the program, a total of nine high school students were able to gain employment with in the community. As of yearend, one student moved out of the district, one student is looking for new employment and seven students have maintained employment independently.

A reception was held celebrating and recognizing the successes of the program, employers, employees (students) families, job coaches and school personnel.

Throughout the duration of the grant 46 students were able to receive supported employment services. Staff were able to provide and assist the students in the following areas of employment development; strategies for finding employment, developing interviewing skills, how to dress for success, completing job applications, and obtaining a work permit. Three Job Clubs were held giving students a classroom setting for career development. Students also assisted with a cooking class offered at the Lake Mills Community Center. Students were coached in a community setting to develop on the job skills. Students toured several businesses within the County and the State.

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BIRTH TO THREE

~Enhancing the child's development and supporting the family's knowledge, skills, and abilities ~

Key Principles

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in a familiar context.
2. All families, with necessary supports and resources, can enhance their children's learning and development.
3. The primary role of the service provider in early intervention is to work with and support family members and caregivers in children's lives
4. The Birth to Three process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs.
5. IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
6. The family's priorities, needs and interests are addressed most appropriately by the primary provider who represents and receives team and community support.
7. Interventions with young children and families members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

Since 1979, the Jefferson County Birth to Three Program has been committed to providing children, age birth to three, with developmental delay and their families with high quality services that promote healthy growth and development. Recognizing the parent or caregiver as the primary source of influence in their child's life, our Birth to Three services focus on working in partnership with families to support their understanding and abilities to create meaningful learning experiences as they interact with and raise their child.

Using the "Key Principles" developed by the Office of Special Education Programs as a guide, the Jefferson County Birth to Three program has established a process that reflects best practice and ensures quality programming. From Child Find activities and receiving referrals to determining eligibility and services needed to support families as their children graduate out of the program, our team of highly qualify professionals employs their expertise to ensure children and their families are receiving the individualized services and supports needed to enhance their everyday activities.

Birth to Three Process

Child Find

"You are an amazing group of people, and we feel so fortunate to have had you work with our family over the last 2 ½ years! We'll greatly miss you all!!!"--- Becky

The Birth to Three program is charged with developing comprehensive systems that ensure that children and families who might qualify for our services find their way to our program. Keeping community resources and families educated about our services and how to obtain them has been an ongoing goal of the program. Child find activities include presenting to community partners (physicians, United Way, Maranatha) about Early Intervention, attending local Children Fairs, and participating in the Child Development Days held by local school districts. Our goal for providing Child Find activities in 2012 was to organize and/or participate in two during the year. Our staff went above and beyond by being a part of six different activities this year.

Referrals

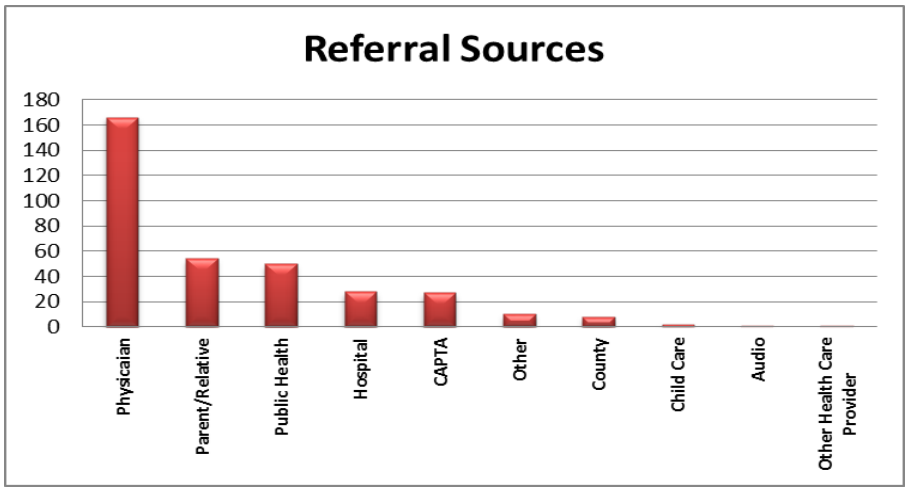
Anyone living in Jefferson County who has concerns regarding a child's development may contact the program to make a referral. We receive referrals from a variety of sources by phone or fax. We are required to connect with the family within two days of receiving the referral to talk about the program with them.

In 2012, the majority of our referrals came from physicians who had concerns that a child might have a development delay after a well-visit check or was concerned that a child had a condition that predisposed him or her to developmental delays. Other common referral sources are parents and relatives, Public Health, WIC and hospitals.

Children can be and are referred at any age from birth to 36 month of age. 44% of children referred to us in 2012 were between the ages of 12 months and 24 months.

Number of Referrals: 234

Age at Referral



Initial Intake

Birth to Three services are to be provided in the child's natural environment, where he or she spends the majority of their time. For our staff, that often means traveling to families' homes for meetings and services. For our two Service Coordinators, this means working efficiently and effectively to travel to each family's home, collect the initial information and paperwork, and complete the Ages and Stages Questionnaire. This questionnaire is widely used to screen children by physicians and Public Health, who then share the results with us. Of the 234 referrals received in 2012, approximately 50% came to us with completed ASQs.

"I was very happy with all the helpful tips and advice I received from all the therapists. They were very caring and developed great relationships with my daughter and me."—Kayla

Evaluation

The Birth to Three program is required to conduct initial eligibility evaluations that involve a multi-disciplinary team. We not only have our own three Early Childhood teachers on the evaluation team, we contract with Rehab Resources to provide our therapies. Currently there are three Speech and Language Pathologists, two Occupational Therapist and two Physical Therapists working with Jefferson County Birth to Three families.

Eligibility and Services

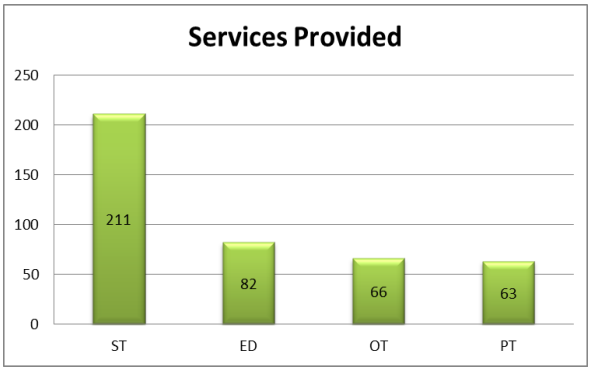
Once the evaluations are complete, the whole team meets to discuss the child's unique strengths and areas of need. If the child is determined to be eligible per DHS 90, the team will develop an Individualized Family Service Plan (IFSP) that outlines the most appropriate services and goals that the team will be working with the family to reach. Goals are developed by the family. They are routine based, activity directed and specific to each child. The services are provided in a coaching model to empower families. Assessment and monitoring the child's development and the effectiveness of the services is ongoing. At a minimum of every six months, the team meets to review and update the plan.

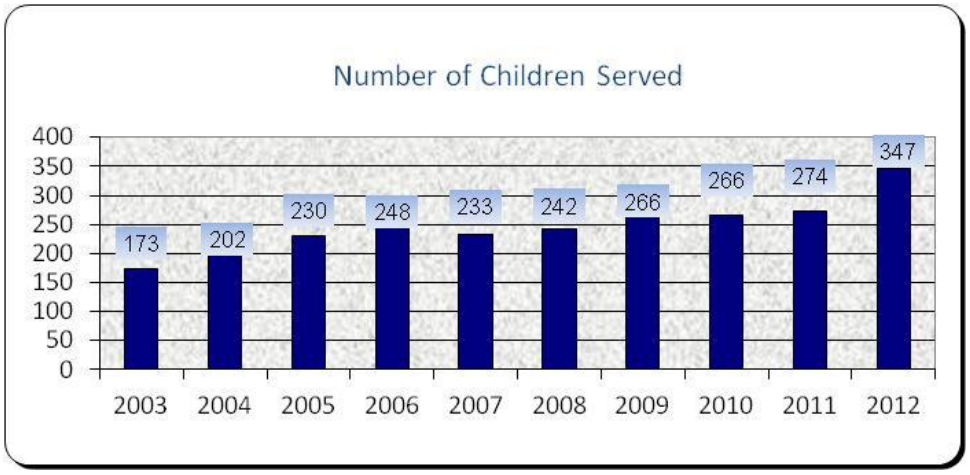
The program was wonderful and the people we worked with were all professional, helpful and friendly. We are glad to have had such a program to help with our little guy and his speech! —Jodi

In 2012, Birth to Three provided services to **347** children and their families.

72% English Speaking Families

28% Spanish Speaking Families





To ensure that all families are getting every opportunity to participate fully in our program, each child is assigned one of our three educators to manage their IFSP. Each of our educators carries a case load of 30 – 40 children, on top of providing educational services. Our bilingual Service Coordinator manages all of the Spanish speaking family's IFSP, along with providing interpretation during services.

214 of the children served in 2012, were continuing the IFSP from 2011.

133 of the children served in 2012, had their IFSP developed in 2012.

Transitions

Transitioning children from one stage of life to the next can be a scary and daunting process. From the initial visit to the child's third birthday, our staff ensures that the family knows that together we will be creating steps to make their child's transition out of our program a smooth one. Children may exit the programs for many reasons. We keep the families informed about all of the options for their child.

"The staff was great to work with. We will miss seeing everyone. Everyone had a great big hand in getting Leslie this far. "LW"

Children and families may be transitioned into program options based on need and eligibility. Our staff is knowledge about community resources and programs that are appropriate for children with development delays over the age of three. They effectively transition children and families into a variety of settings.

110 families participated in transition meetings with local school districts in 2012

REVIEW OF 2012 GOALS

1. Continue Child Find activities. The goal was to complete 2 activities. The program completed 6 during 2012.

2. To provide service coordination to families and to have 80% billable time. The program had an average of 85%.

3. To participate in the Incredible Years Parenting Program. The program acted as group leaders, as well as providing child care.

4. The team continued to provide evidenced based practices. Individualize Family Service Plans were written with routine based outcomes.

5. Continue to have Birth to Three staff work in a collaborative team approach with other agencies.

6. The Birth to Three staff attended agency "super staffings" regularly, as well as collaborated with school, clinics, and the health department.

2013 GOALS

1. Will begin implementing the Primary Service Provider Approach to working with children and families.

2. Will educate five families about the Incredible Years Parenting Group and assist them in signing up to participate in the group.

3. Will develop informative and family friendly exit surveys that will be completed by the family at 100% of discharge meetings. This survey will be completed by the appointed survey committee by August 2013.

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BUSY BEES PRESCHOOL

~Providing positive early learning experiences throughout a fun-filled morning ~

Busy Bees Preschool is a program for two and three year old children that opened in September 2005. The preschool is open Tuesday and Thursday mornings from 8:30 a.m. to 11:00 a.m. The preschool runs from September through May. A summer session is also offered in July and August. When full, the preschool runs with twelve children in the classroom with at least two teaching staff. The students who enroll in Busy Bees Preschool are a combination of community peer models and children enrolled in the Birth to Three Program.

Busy Bees Preschool provides a positive environment that is rich with learning experiences. The children's day is planned using a consistent routine that enables children to follow expectations and become successful. The activities that fill the children's day emphasize language and concept development through free play, music, finger plays, books, gross and fine motor activities, art experiences, and daily living skills, including a snack time and bathroom routine. The activities and lesson plans are designed to incorporate the Wisconsin Model Early Learning Standards.

The preschool is staffed by three full time educators with over twenty-five years of combined experience working with young children. All of the teachers hold Bachelor's Degrees in Education and a Wisconsin Teaching License in the area of Early Childhood. The teachers are also part of the Wisconsin Registry for Educators. In addition, licensed Speech Therapists, an Occupational therapist, and a Bilingual Service Coordinator provide individualized support based on the unique strength and needs of the children.

Children increase their social skills, self-esteem, and overall confidence through understanding and succeeding at our preschool. It is a place for children to develop independence and learn to BEE themselves!

"I am extremely grateful my daughter attended Busy Bees Preschool. Over the last 10 months she has learned to talk to her peers and is much more comfortable away from home. All the staff and people involved with Busy Bees are wonderful"---Stacey

* * *

CHILD ALTERNATE CARE

"Providing for the physical, emotional, and social needs of the child until the child can be reunited with his or her family."

Our Alternate Care services provide access to a wide range of services and out-of-home placement options for children. Alternate Care remains a very important priority service and great care is taken in making these placements based on fit, well-being, potential reunification success and proximity. These services were developed to provide for the physical, emotional, and social needs of the child until the child can be reunited with his or her family. When family reunification is not possible, other forms of permanency are utilized such as independent living, various forms of guardianship, adoption and other planned living arrangements (OPLA).

It is intended that through respites, short-term placements, regular family interactions, and supportive services, children will be reunited with their families as soon as diminished protective capacities are increased, community safety is not at risk and in-home safety threats can be mitigated. Out-of-home care providers are an integral part of a team concept working toward the goal of successful permanency along with the birth family, extended family, informal and formal providers, as well as the case manager. Children who need out-of-home placement require a great deal of social work time, effort and funding in order to achieve a successful return to home.

ALTERNATE CARE PHILOSOPHY

- To avoid placements whenever possible, by providing protection, support and services in our communities.
- To work towards permanence for the child from the moment of out-of-home placement. The first choice is often to strengthen the child's family system and reunify that child.
- To keep placements short in duration and make them within the community whenever possible.
- To identify the factors in the family that create unsafe situations, as well as the family strengths and resources to build upon positive pre-existing conditions while dealing with the underlying needs.
- To minimize the use of institutional placements by creating unique community options with providers.

We are required by state mandate to license kinship homes (children residing with a relative) as "Level One" foster homes. In 2011, our department licensed homes and placed 71 children into Level One and/or kinship homes (family members) to avoid a more restrictive placement setting with a caretaker with whom they were unfamiliar. In 2012, we were able to place 75% (54 of 72) new children needing out-of-home care into a familiar placement setting with a relative. This is a major accomplishment toward limiting the trauma that is associated with any removal from home. The licensing of these kinship homes has required additional staff time, resources and creativity, but remains best practice and a goal that begins the instant an out-of-home placment is needed. Additionally, we were required to further implement the levels of care licensing for all children's alternate care providers. The level of care needed is determined by the child abuse and neglect assessment tool. Rates for all providers are set by the state.

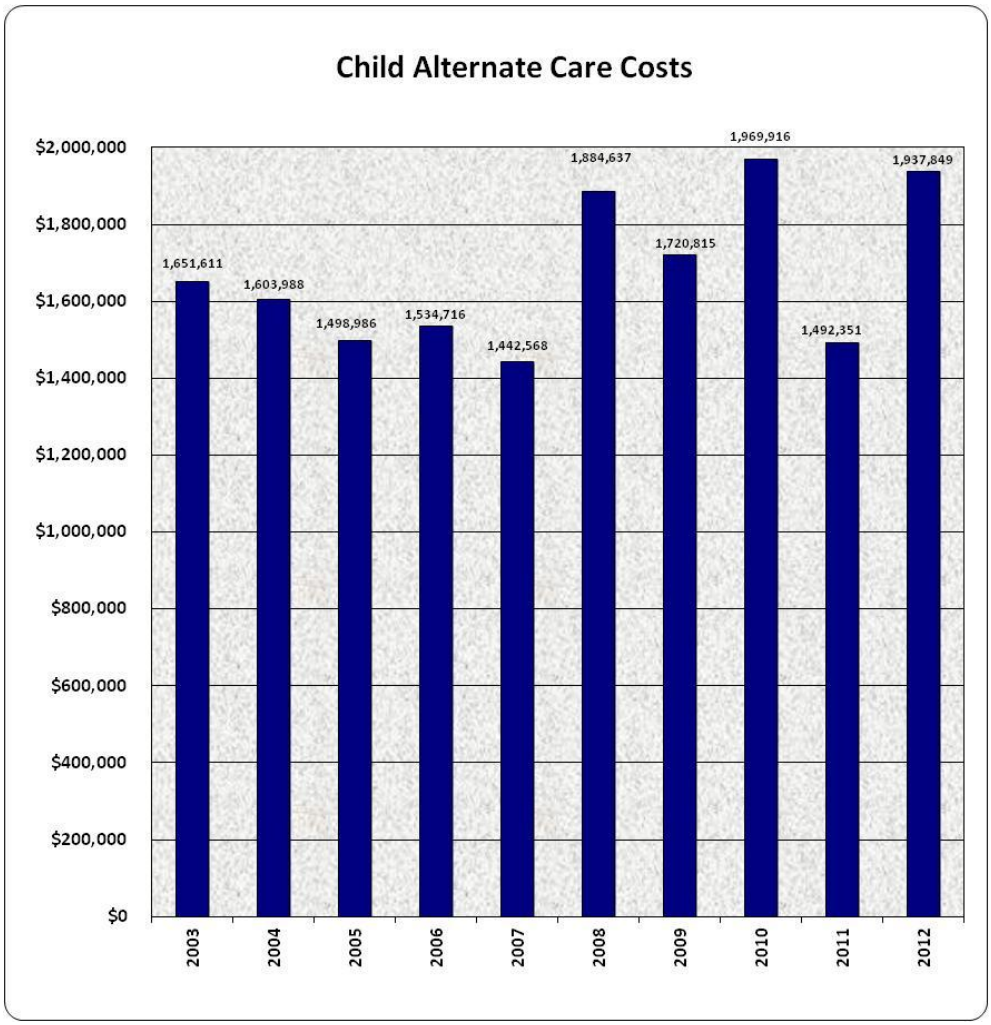
Furthermore, our agency has worked diligently at returning children home in a timely fashion, while maintaining safety in the home and without sacrificing safety of the community. The number of <u>new youth</u> entering care in the calender year went from 76 in 2011 down to 72 in 2012. The number worthy of note is the number of children discharged back into the community or returned home in a given year, in conjunction with the number of placements which gives us our plus or minus ratio of additional children in care each year. As you can see below, our staff have worked dilligently to return youth safely home in 2012 with assistance from increased placement scrutiny, Permanency Rountables (PRT's) and increased safety planning in part from a recent safety services grant from DCF.

Entries and Discharges of Children by Calender Year			
Year	Children entering care	Children exiting care	Plus/minus ratio
2012	72	68	+4
2011	76	53	+23
2010	61	56	+5

It is worthy to note that of the 72 children that entered care in 2012, 87.5% (52) were discharged with a legally recognized form of permanency by the Department of Children and Families (DCF), which is slightly ahead of the state average of 87.3%. The break down of the various forms of permanence found via discharge consisted of the following:

- 72.2% were reunified to a parent, while the state average was 61.4%
- 11.1% were discharged due to the department setting up a guardianship
- 4.2% were adopted
- 1.4% were discharged via independent living
- 1.4% found permanency via other arrangements
- 9.7% reached the age of majority

In 2011, the department was able to decrease spending on alternate care for children by $477,565 from 2010. Unfortunately, the spending increased in 2012 to that of the spending in 2010 in part due to two unforeseen high cost placements that were privately petitioned by families oustide the traditional relm of Human Services. Alternate care spending is of course a huge priority and concern for the department each and every year, both fiscally and for child well being. Children and adolescents need permanence, safety, and well being, and while out-of-home placements and multiple placements are necessary to assure safety at times, we know that these situations can be associated with poor lifetime outcomes for children. The department attempts to avoid placements and deter costs in several ways. We have continued to contract with the state to retain legal counsel for situations that require termination of parental rights. We are continuing to use the Community Recovery Service benefit (C.R.S.) for youth who have mental health needs, which allows for more in home supports. We are increasing the number of children on long term support waivers and are implementing parenting coaches. In 2011, the department began to utilize subsidized guardianships as an option through Chapter 48 of the children's code to assist children in achieving permanency through a funded guardianship, in cases that otherwise would result in long term out-of-home placement and we have continued this trend in 2012. Finally, our department relies on the use of respite care to avoid a long term placement by providing a short reprieve for parents and their children. We provided 483 respite opportunites in 2011, and provided 518 respites in 2012 across both the Child and Families Division and the Behavioral Health Division. A handful of youth account for multiple respites to avoid high cost and traumatic initial placements, as well as to preserve a variety of current placements. We are confident these services will provide better outcomes for our youth of Jefferson County.



The Department of Children and Families measures each county on a number of placement related performance items which is directly related to the Federal Child and Family Services Review (CFSR). Below is a breakdown of the placement related items:

- Timeliness to reunification is a federal benchmark that indicates that children who are returned home should be returned home within 12 months of placement. Jefferson County sent 73% of it placements home within 12 months of removal, which is in line with the state average and just under the federal benchmark of 76.2%.

- Placement stability is a federal benchmark that indicates that of all children placed outside the home for less than 12 months, these children should have no more than 2 placments during that placement episode. Jefferson County was able to accomplish this about 73% of the time which is below the state average of 83% and below the federal benchmark of 86%.

- Re-entry into out-of-home care is a federal benchmark that tracks the re-entry rate of children BACK into care after the discharge from a placement. Jefferson County had only 10% of children re-enter care after discharge which is better than the state average of 14% and just off the federal benchmark of 8.6%.

- Maltreatment in out-of-home care is a federal benchmark that tracks substantiated abuse to a child by a facility or foster parent while placed in their care at a rate of 0.57% or less. Jefferson county had 0 incidents of substaniated abuse of children while in care in 2012, which is better than the federal benchmark and the state average.

The following chart exemplifies Jefferson County's placement of youth into some form of out-of-home care from 2007 through 2012. Most individuals requiring placement can be maintained at the foster home level, while others require more restrictive placements such as group home, residential care, or as restrictive a setting as we have available, juvenile corrections. As the numbers below indicate, we take great measures to avoid these types of highly restrictive settings and utilize those only when community safety cannot be controlled. Because the needs of children who require alternate care are high, programming efforts, particularly mental health services, are used in conjunction with placements. The 158 different placements made in 2012 are as a result of placement activity by all of the youth that were in placement at any time in 2012. This number occurs due to very short Temporary Physical Custody Placements all of the way to long term placement episodes. Additionally, the number indicates that we have the need for multiple placements per child, due to court ordered changes, moving from more restrictive to less restrictive as the juvenile re-integrates back into the community, as well as placements that are not a quality fit for the child or juvenile which necessitates a change.

ALTERNATE CARE PLACEMENTS - CHILDREN

PROGRAM	2004	2005	2006	2007	2008	2009	2010	2011	2012
Foster Care (In-County)	24	30	28	46	25	34	53	61	59
Foster Care (Out-of-County)					14	13	16	37	17
Treatment Foster Care (In-County)	6	12	7	7	2	9	11	3	12
Residential Care Center (Child Care Institution)	17	7	5	8	8	13	18	6	5
Child Correctional	4	3	1	1	1	1	4	3	1
Child Mental Health Institute	4	4	3	4	2	2	2	1	4
Out-of-County Treatment Foster Home	11	12	21	22	27	33	52	24	42
Out-of-County Group Homes	17	23	17	12	14	16	29	12	18
TOTALS	83	91	82	100	93	121	185	147	158

Detention Placements

A final related statistic in the Child Alternate Care area is our use of secure detention (locked juvenile detention facilities) for youth. During 2011, 47 youth were placed in these facilities at a cost of $33,340, which is a decrease from 69 youth in 2010 at a cost of $78,790. This is a cost savings of $45,450 or 42%. In 2012 we continued to decrease our utilization of detention as only 35 youth were placed in detention. This is a two year decrease of 34 secure placements. These placements are either made by the Juvenile Court or by Human Services staff in order to provide community protection or to sanction youth for violation of a court order. Many alternatives to the use of secure detention were utilized to decrease the number of these placements such as Intensive Supervision, electronic monitoring, respites at group homes, and other deterrents made via the case manager and the treatment team. The child and family division takes great pride in keeping the community safe, while limiting the use of secure detention.

DETENTION CENTER PLACEMENTS

2012

COUNTY	NUMBER OF PLACEMENTS		TOTAL COST
Rock Co Detention Center	26	$	32,175.00
Waukesha Co Detention Center	9	$	11,891.00
TOTALS	**35**	**$**	**44,066.00**

* * *

CHILDREN'S LONG TERM SERVICES

~ Assessing children and family needs and supporting a plan for the provision of services~

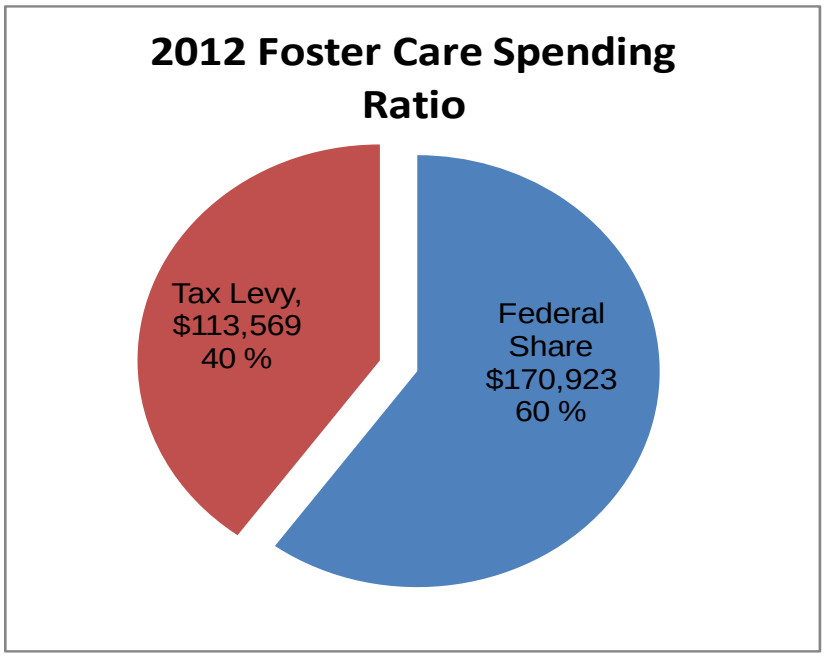
The Medicaid waiver programs are built upon a foundation of primary program values. These values support individual choice, the enhancement of relationships, building of accessible and flexible service systems, achievement of optimum physical and mental health for the participant, and the promotion of presence, participation and optimal social functioning in the community. The program values further seek to ensure that participants are treated with respect and assure that service systems empower the individual, build on their strengths, enhance individual self-worth and supply the tools necessary to achieve maximum independence and community participation.
The children's long term support team provides services to children who are eligible for Medical Assistance and have met the criteria as developmentally disabled, physically disabled or are severely emotionally challenging. These children can be served through the children's long term support waiver or the family support program.

Children's Long Term Support (CLTS) MA Waiver funding can be used to support a range of different community services that assist the child to live successfully in the home and community. The services that are selected for the child are based on an individualized assessment and service plan completed by the local CLTS Waiver agency in consultation with the child's family. The assessment identifies the child's needs, and the service plan identifies which services will be used to meet the identified needs.

Examples of different services that were provided to families in 2012 include; adaptive aids, communication aids, supportive home care, specialized medical supplies, daily living skills and respite care to name a few.

- In 2012 seventy three children received long term support services.
- In 2011 seventy six children received long term support services.

When a child is enrolled in the Children's' Long Term Support program and placed out of the home but in an eligible setting, the County pays 40% of the cost of the monthly placement costs with the waiver (Federal Share) paying 60% of the monthly placement costs. As evidenced by the chart below, using the Federal dollars for foster care placements provided a cost savings of $170,923.00 for the County in 2012.



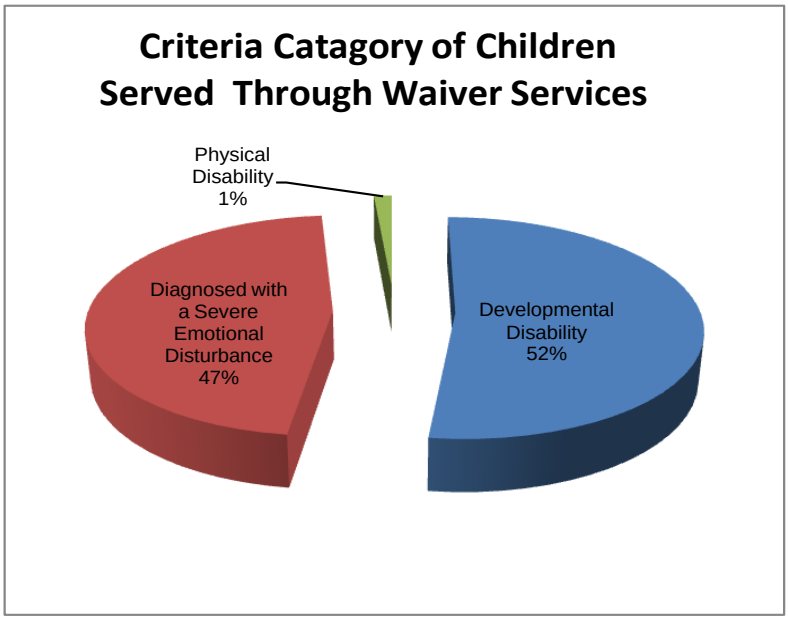
- In 2012 the total cost for foster care (waiver children only) was $284,492

Furthermore, utilizing the Waiver program and the corresponding Federal Share Jefferson County has produced a two year savings of $461,659 to the alternate care budget, while meeting the family's needs.

Seventy three children received Children's Long Term Support Services. The graph identifies the target group (criteria) of the participants receiving services:

- Children with a Developmental Disability – 38
- Children diagnosed with a Severe Emotional Disturbance – 34
- Child with a Physical Disability – 1

Jefferson County currently has 72 children on our waiting list for services.



REVIEW OF 2012 GOALS

1. Waiver program staff developed a rate setting tool for respite service providers. This tool was developed to curtail inappropriate rate requests and to have a uniform baseline of service provision.

2. A waiver provider summary of services form was developed for mandated documentation to meet State guidelines and to show the progress of individualized goals.

3. A recommendation was made to search for another fiscal agent. After searching and gathering information our agency was able to find a new fiscal agent at a substantial cost savings to the county budget. All changes were made internally and externally to have this go into effect on January 1, 2013.

4. Monthly meetings occur with our fiscal department to address State changes, internal changes and to collaborate on services being provided affecting the annual budget.

5. The referral process changed making the process a streamlined approach for families. Families make one contact linking them to Threshold. Threshold is the doorway to apply for children's long-term support services (CLTS). Families may apply for one or several CLTS programs for their child through Threshold with a single application.

2013 GOALS

1. Collaborate with the children's division, alternate care and fiscal to identify children who may meet criteria for Children's Long Term Support services as a cost savings mechanism.

2. Conduct regular monthly internal audits on all CLTS cases in 2013.

3. Review monthly teleconference information at our weekly meeting following the conference.

4. Develop a methodology for 95% accuracy for quality assurance of case management and mandated criteria for internal and external auditing.

5. Routinely review all documentation with respective staff.

* * *

INDEPENDENT LIVING

~Helping young adults become independent, responsible and productive members of society when they reach adulthood~

The Independent Living Program is a partially Federally sponsored program for youth in out-of-home placement to help them enhance personal daily living skills that will help them become independent, responsible, self-sufficient and productive members of society when they reach adulthood. This is a mandated service for any youth 15 - 17 years of age with a 6 month out-of-home care placement. In 2012, there were 27 youth eligible for Independent Living Services. Youth can continue in the program until they reach 21 years of age.

Youth ages 15-17 years

Youth in out-of-home placement, ages 15-17, complete a life skills assessment and develop an individual living transitional plan with the assistance of the Independent Living Services Coordinator. Youth develop personal goals and identify individuals who can assist them in reaching their goals while supporting their transition from a youth to a young adult. Services are provided on an individual basis or in a group setting when appropriate. Transition goals are developed by the youth with the assistance of the Independent Living Services Coordinator, on-going case worker, foster parents or group home provider and the youth's natural supports, such as parents, grandparents, aunts and uncles, cousins, friends, teachers, faith providers, and other community members the youth feels makes a positive difference in their lives. Progress is monitored by team members on a regular basis.

In 2012 there were 16 youth ages 15-17 eligible for Independent Living Services. Eight of these youth resided in another county. All of these youth received an Independent Living Services assessment and had face to face contact with the Jefferson County Independent Living Coordinator.

Youth ages 18-21 no longer in out-of-home care

Young adults ages 18-21, who are no longer in out-of-home care, complete a life skills assessment to determine the areas of on-going need, identify personal goals and develop a transitional discharge plan. The transitional discharge plan incorporates the youth's on-going needs with their personal goals. The Independent Living Services Coordinator assists the youth with their transitional discharge plan and offers assistance with educational planning, career development, employment, housing, transportation, child care issues, family planning, accessing community resources, managing AODA issues, building healthy relationships, risk prevention as well as other concerns the youth might be experiencing or may be expected to encounter.

In 2012 there were 5 youth that were discharged from this program due to:

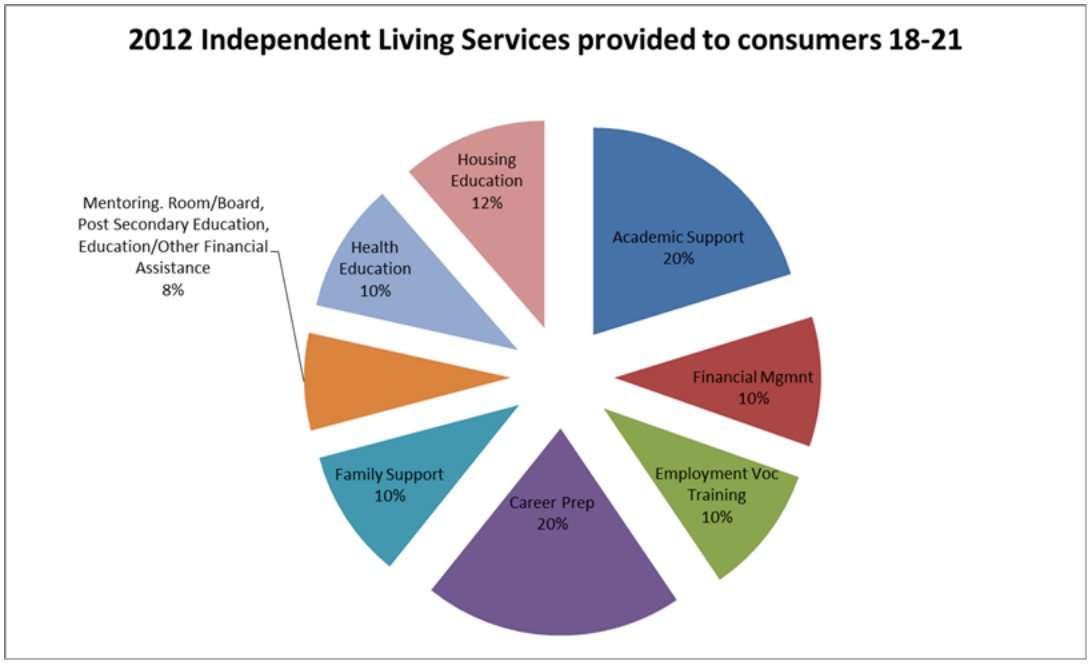
Number of Youth	
3	Reunified with their family
2	Change in guardianship (family member)

Of these youth receiving Independent Living Services, and dismissed from the system, the following occurred:

Number of Youth	
3	Reunified with their family or a family member.
1	Aged out of the system.
4	Enrolled into secondary education.
0	Secured an apartment / house.
0	Homeless with no place to go.
1	Returned to family or family members
0	Staying with friends, but no permanent place to live
0	Entered into criminal system
0	Other -

Service Category and Number of Youth Served:

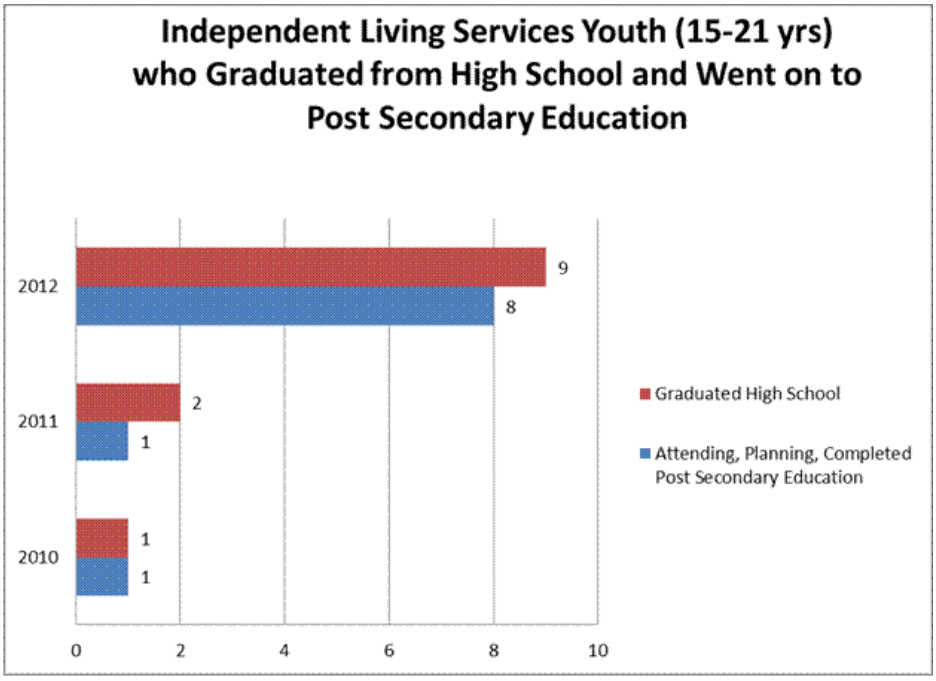
Academic Support	**16**
Budget and Financial Management	8
Career Preparation	18
Education and Financial Assistance	0
Employment Programming or Vocational Training	8
Family Support/Healthy Marriage Education	8
Health Education and Risk Prevention	8
Housing Education and Home Management Training	9
Mentoring	1
Other Financial Assistance	1
Post Secondary Educational Support	4



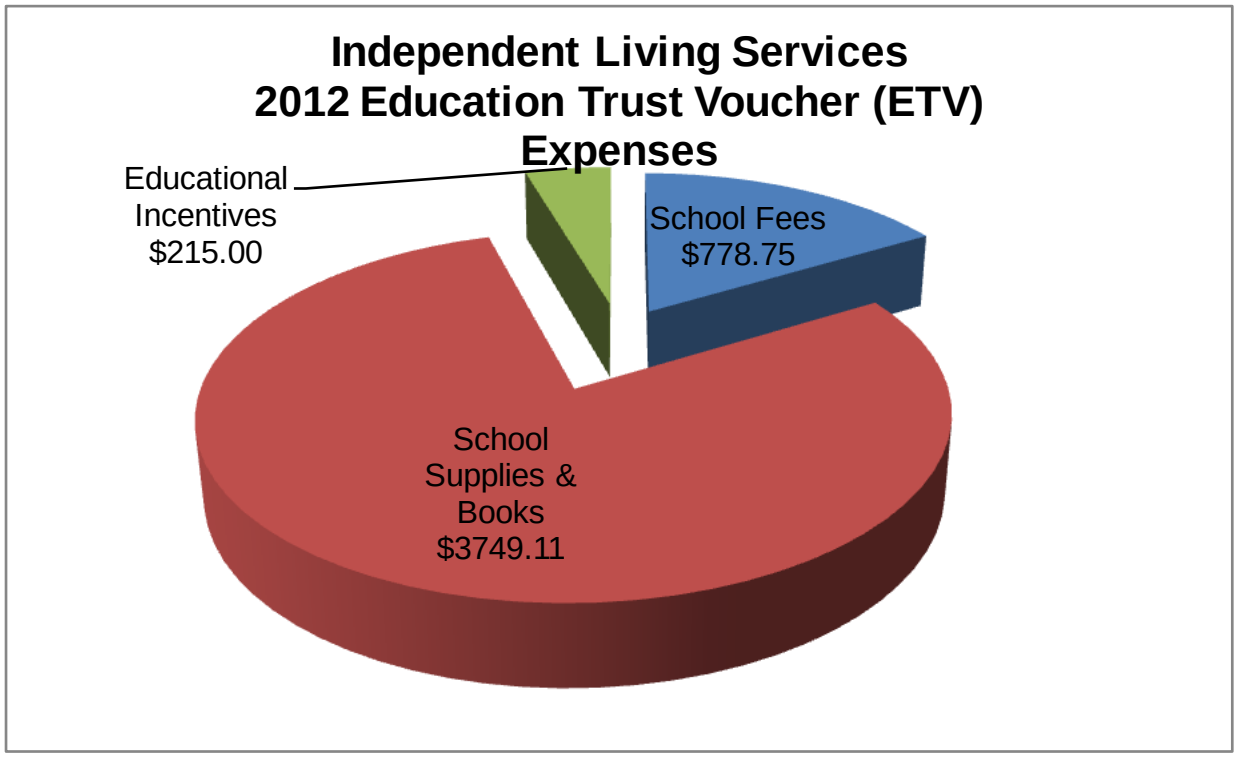
2012 activities that youth 15-21 years of age participated in, the type of activity, setting/structure and the number of youth that participated:

Activity	Setting/Structure	Youth that Participated
Youth was chosen to participate in a statewide training video for court officials & guardians to encouraging youth participation.	Youth was recommended by Wisconsin Department of Children & Families to participate in a statewide video.	1
"Rent Smart" training with youth to document how to rent your first apartment and be a good tenant.	IL Coordinator taught, coached & demonstrated to youth about challenges with locating, securing & maintaining housing and how to be a good tenant	6

IL youth participated in volunteer work within the community which assisted them with gaining other employment.	**IL Coordinator developed a relationship with a Chamber of Commerce where youth were allowed to demonstrate their current abilities while gaining additional knowledge on employability skills. Youth that participated have gained additional employment. These youth were allowed to use this volunteer opportunity on their resume.**	**2**



Of all youth that were expected to graduate in 2012, 90 % graduated on time with the other 10% obtaining a GED.



REVIEW OF 2012 GOALS

1. The Independent Living Program excelled in the area of assisting youth with post-secondary education. This is reflected in the above graphs identifying the number of youth who attended post-secondary education and the Educational Trust Voucher dollars that assisted the youth with their educational needs. In 2012, 88% of all youth who graduated from High School went on to attend post-secondary education.

2. A resource manual was developed with pertinent information and resources pertaining to housing, legal action, how to obtain a birth certificate, new social security card, picture ID and any other resources or documents that you would need to become a successful independent adult.

3. Our Independent Living program has been recognized throughout the State for leading youth into adulthood. Our Independent Living coordinator participated on a panel and was the guest speaker at the State Independent Living Conference. A brochure has been developed and has been distributed throughout the County and State.

4. All youth receiving Independent Living services continue to be on track for graduating with their graduating class. This is due to the motivation of the youth wanting to complete their person centered goals developed in their plan, school contacts that are made with the IL coordinator and teaming with school guidance counselors for the success of the youth.

2013 GOALS

1. Provide an educational group for youth using the "Rent Smart" curriculum that was developed by UW Extension. This workshop is a 12 week program that provides the necessary skills needed to live independently. These workshops will include presentations in the community as well as visits to apartments, discussions with landlords and their rental procedures. Successful completion of this workshop will be evidenced by a certificate. Staff will continue educating area landlords to understand the benefit of this certificate, accept this certificate where a youth might have been denied earlier, and allow youth the opportunity to successfully gain the first step of independence. Housing is one of the toughest challenges a young person can experience with little to no income, no rental references, and the trauma they experienced as a child.

2. Provide youth with two advocacy opportunities throughout the State and County allowing them to have a voice in their future.

3. Increase number of youth attending post-secondary education by 10%, by introducing the option of enrollment into the Independent Living program and by supporting them through teaming with school personnel and informing and assisting them with scholarship opportunities.

4. Develop and implement a quarterly regional meeting with in the South Eastern region for IL programs and coordinators to share information and educate each other on program policies and procedures.

* * *

ECONOMIC SUPPORT DIVISION

Providing and Coordinating Resources to Strengthen Families

Access to quality customer service, timely, accurate processing and connections to resources are the focus of the Economic Support Unit.

The Economic Support Programs for Jefferson County are administrated at the Workforce Development Center. Our location at the Workforce Development Center provides staff with the ability to coordinate the services of the on-site providers: Job Services, Department of Vocational Rehabilitation, Opportunities, Inc., WORKSMART Programs, and the Jefferson County Economic Development Consortium. Community Partner connections also result in improved service coordination. These partners include: Community Action Coalition, Madison College, local School Districts, PADA, food pantries, Faith Based Organizations, St. Vincent de Paul and local employers. Employment services are provided regionally to facilitate coordination of customers who live in one county and are employed in another.

If you are interested in learning more about the current job listings available to meet your workforce needs, you can visit the website of www.jobcenterofwisconsin.gov for a statewide listing of employment opportunities. We also provide monthly calendars at the WDC showing the dates of employment workshops, skills training and job fairs. In 2012, 19,545 duplicated visitors accessed the WDC services. If you have questions, please contact our office at 920-674-7500.

In December of 2012, our Economic Support programs provided assistance to 7,177 Jefferson County households. Per the 2010 Census data the percentage of households in Jefferson County whose income is below the poverty level was at 9%. Customers may be receiving assistance from Medicaid, BadgerCare Plus, FoodShare or Wisconsin Shares. Further, our customers may receive financial assistance from St. Vincent de Paul or Energy Assistance.

Following is a brief description of each program and the number of customers who received these benefits in 2012.

ECONOMIC SUPPORT DIVISION TEAMS

Wisconsin Works

Economic Support

ECONOMIC SUPPORT PROGRAMS

~Providing stronger financial stability for low income households, and those experiencing a financial loss~

The Economic Support Programs serve to provide stronger financial stability for low income households and those experiencing a financial loss. Often our services are necessary to meet an emergency need such as homelessness or medical needs. Each program serves a specific population and has different income guidelines and requirements. The self-sufficiency of Jefferson County households and individuals is the ultimate program goal. Requesting financial assistance from Economic Support Programs continues to grow each year.

Caseload Growth

2009	5,237 households receiving assistance
2010	5,676 households receiving assistance
2011	6,020 households receiving assistance
2012	7,177 households receiving assistance

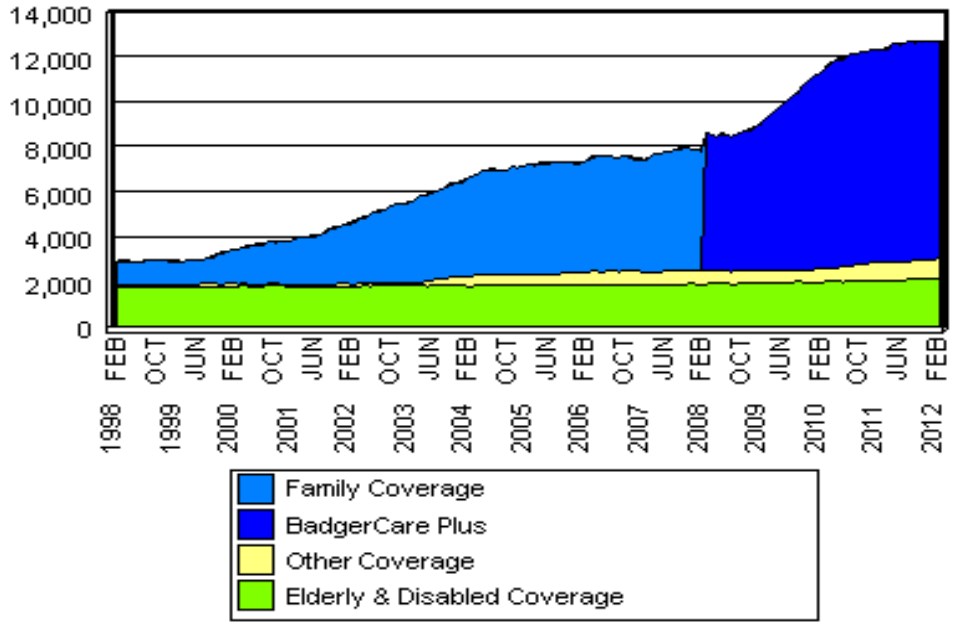
Requests for program assistance are made by contacting the Workforce Development Center at 920-674-7500 and asking to speak to an intake worker, coming into the agency, or calling Southern Consortium Call Center at 1-888-794-5780. The Financial Employment Planners serve as the first point of contact for all customers. They assess the customer's needs, initiate the application process and coordinate the appropriate referrals to community resources. The ACCESS website at www.access.wisconsin.gov also can be used to apply or report changes to your household.

MEDICAL ASSISTANCE - is a State and Federally funded program that provides the low income customer comprehensive affordable healthcare. Numerous individual programs are included in the umbrella of Medical Assistance including; BadgerCare Plus, BadgerCare Core Plan, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary, Family Care and Nursing home programs. Each program has its own specific non financial criteria for eligibility. The eligible customer receives a white Forward card which is taken the Health Care provider to verify coverage. Most Medical Assistance customers must participate in a Health Management Organization. At the Medicaid website http://dhs.wisconsin.gov you can access information on the individual program benefits and requirements.

The following chart shows the number of customers receiving Medical Assistance in Jefferson County. In 2011, we provided Medical Assistance coverage to 12,713 customers. In 2012, the number of customers eligible for benefits decreased to 12,453. The graph displays the increase of eligible households over the last few years.

Recipients of Medical Assistance

Caseload on December 30	Families	Nursing Home	Elderly Disabled	Totals
2009	8,354	271	1,906	11,110
2010	10,117	243	1,976	12,356
2011	10,331	243	2,139	12,713
2012	10,008	227	2,218	12,453



FOODSHARE-FOOD STAMPS - is a Federal Program that provides a monthly Foodshare allotment to low income customers. Eligibility is based upon income, household composition and shelter expenses. The eligible customer receives a QUEST card that is used to purchase food at local grocery stores which supports our local economy. Customers in search of employment may volunteer to participate in the FSET program and work in coordination with a Finanacial Employment Planner to develop their employability resources. Foodshare participation continues to increase. The Foodshare caseload in 2011 was 11,499 receipents with a total average monthly benefit issuance of $753,849 to be used to purchase food in our local communities. In December 2012, the caseload was 13,499 receipents with a monthly benefit issuance of $961,232. The chart below shows the increase in the number of Foodshare customers from 2009 to 2012 in Jefferson County. The Foodshare website is http://dhs.wisconsin.gov/foodshare.

FOODSHARE

Year	All Recipients	Adults	Children	Groups
2009	8,594	4,369	4,282	3,457
2010	10,511	5,334	5,246	4,137
2011	11,499	5,964	5,627	4,649
2012	13,438	7,501	6,032	6,010

WISCONSIN SHARES-CHILD CARE - is a program that provides child care subsidies for low income working families to assist in their payment of child care expenses. The subsidy payment is made to the child care provider, with the family responsible for the co-payments. In 2011, the monthly average of families receiving child care assistance was 254 households. In December 2012, the number of families receiving child care assistance was 208 households with authorizations for 306 children. Additionally, the Child Care case managers certify in home child care providers, participate in local children's fairs, and present trainings for providers. The child care website is http://dcf.wisconsin.gov/childcare/wishares.

JEFFERSON ST. VINCENT DE PAUL SOCIETY - provides our division access to local funds for the School District of Jefferson's customer's emergency needs such as rent and utilities, unmet by other programs. The household will only receive a specific payment amount once in a 2 year time period. In 2011, 183 households received $20,502.31 in emergency funding. In 2012, 191 households received assistance totaling $22,161.56. Their generosity continues to be greatly appreciated.

EMERGENCY ASSISTANCE - is a program designed to meet the immediate needs of an eligible family facing a current emergency of fire, flood, utility disconnect, homelessness or impending homelessness. In 2011, 68 households received $33,618.07 with an average grant of $494.38 per household. In 2012, 77 households received $38,438.04 with an average grant of $499.20. The need for this program remains constant as families struggle to meet daily living costs.

ENERGY ASSISTANCE - is a program that provides a single payment during the heating season to low income customers who need help paying their heating costs. The energy payment is made directly to the fuel supplier. Jefferson County continues to contract with Energy Services to administer the program. In 2011, 2,702 households received $1,302,372 in energy assistance payments with crisis funding to 456 households in the amount of $178,487. In 2012, 2,597 households received energy assistance in the amount of $1,110.807 and 42 households received additional crisis funding in the amount of $168,545 with the average crisis payment being $395. Program information can be found at http://heat.doa.state.wi.us.

REVIEW OF 2012 GOALS

1. **QUALITY CUSTOMER SERVICE -** In 2012, the Economic Support Division began as a partner in the Southern Consortium Call Center and the goal to provide quality customer service became a major focus. As the customers were now directed to contact the consortium 800 phone number and not their caseworkers directly, many were confused and lost in the new system. Staff continues to serve any customer who contacts their caseworker directly or comes in to the office for services. Customers are also able to provide any needed documentation directly to our office if preferred. We encourage customers to use the consortium call center process because it can be more efficient, but it is not an absolute. Additionally, we have a bi-lingual staff member who is able to translate program requirements for the Hispanic population. The Jefferson County Economic Support Agency is known as an agency that puts the customer first and we continue to make every effort to meet that goal. Customer satisfaction surveys are sent randomly and reviewed. Previous responses included "you guys are great" and "I was treated well and received attention in a timely manner". We believe we have met our quality customer goal despite the changes and will continue to make this a priority.

2. **TIMELY AND ACCURATE PROCESSING OF BENEFITS -** As the number of customers requesting assistance continues to increase the State has provided additional tools to help staff manage their caseloads. We have completed intensive training on these tools and pending cases continue to be processed timely within the 7 or 30 days requirement. Our consistency in processing benefits accurately and timely affects the performance standards for the entire consortium so this remains a priority. In 2012, our healthcare error rate was 4.9% and the FoodShare error rate was 6.1%. In 2012, we moved staff offices so they are located by others who complete similar tasks, refined our intake process, and have established a system to delegate work that needs to be done quickly. All staff contribute to the unit's ability to manage the large volume of work by establishing strong organizational skills and helping co-workers when needed.

3. **ACCESS TO RESOURCES FOR EMPLOYMENT AND OTHER FINANCIAL SUPPORTS/RE-ESTABLISH WORKFORCE DEVELOPMENT CENTER INTERAGENCY MEETINGS -** The agencies within the WDC continue to work together to serve our customers. These services include job search preparation, workshops, one on one assistance and providing information regarding other resources. In 2012, we began forwarding all staff current job listings, job fair information and available community workshops. We began joint meetings with other partner staff and will begin to have quarterly interagency meetings to be assured that all staff know the contacts and resources available. We began as a One Stop Shop in 1999 and continue to build upon our employer contacts to benefit both the customer and employer. Further, we developed stronger relationships with Second Harvest to assist customers especially the elderly to apply for FoodShare and are working closely with the Health Department in joint meetings to keep them aware of the current and upcoming healthcare changes.

4. **CONTINUE TO ENHANCE THE COORDINATION WITHIN THE CONSORTIUM CALL CENTER -** This continues to be a work in progress and we appreciate the collaboration with the other counties. We have developed a system of meeting minutes for the supervisors and the call center agents as well as an SOS system. We continue to have staff trainings together so staff are able to develop stronger working relationships with other county staff and have established processes to meet our performance standards and common goals. This includes assessments of all staff training needs.

5. **DEVELOP A SHORT REFERENCE GUIDE FOR CUSTOMERS ON HOW TO APPLY FOR BENEFITS -** This was not fully accomplished due to the constant changes from State and consortium directives on how customers should contact the call center and for what reason, but we will continue to work towards a comprehensive, understandable solution.

2013 GOALS

1. **TO INCREASE EFFICIENCY IN CALL CENTER RESPONSES AND PROCESSING-** As a consortium we are considering developing teams to process specific work items such as reviews, documentation and the actual processing of specific types of benefit cases like expedited FoodShare applications. Further, we may establish several lead staff positions within the consortium who would be the experts to go to on specific topics. Both of these initiatives are designed to increase efficiency.

2. **DEVELOP CONSISTENT METHODS FOR STAFF TRAINING AND AN EFFECTIVE SYSTEM FOR THE RESOURCES NEEDED TO BE READILY AVAILABLE -** Currently discussions on program changes and training are completed at weekly staff meetings through a variety of methods. We receive program information through e-mails, memos, on line trainings, webinars, legislative and State reports and from other community agencies. We need to develop a consistent format to present, organize and maintain resource material.

3. **DEVELOP A SYSTEM TO CONTACT THE CUSTOMERS DIRECTLY TO PREVENT UNTIMELY ACTIONS THAT AFFECT THEIR BENEFITS -** When a household applies for assistance they are required to provide verification, submit reviews and report changes timely. Very often the customer does not contact the agency until their benefits have closed for not completing the requirement. This creates a large workload at specific times of the month, causes the customer to be in an emergency situation (they do not have medical coverage when urgently needed) and prevents the staff from developing and maintaining efficient work processes. We plan to use the NIATX model to develop an effective improvement process to address these issues.

4. **IMPLEMENT REQUIRED CHANGES DUE TO PPACA INCLUDING THE OPERATION OF THE EXCHANGES -** As we begin 2013, it will be another year of dramatic changes for the Economic Support Program Division in Jefferson County. The Federal Patient Protection and Affordable Care Act (PPACA) will change the requirements and processes to receive healthcare benefits. The methods to determine eligibility, changes in the eligible population, and the connection to the Federal HealthCare exchange are all currently being reviewed and created. There will be an additional workload to accommodate the enrollment of those individuals who are not currently eligible for healthcare as well as assistance to individuals who are eligible for insurance through the Marketplace. Continual change remains a constant in the administration of Economic Support programs and we are ready to learn, understand, explain and adapt to these new initiatives.

WISCONSIN WORKS (W-2)

~Focusing on alleviating the specific employment barriers by providing intensive case management and service coordination~

Jefferson County has administered the W-2 program since 1997. The W-2 program focuses on alleviating the specific employment barriers a family member may have by providing intensive case management and service coordination. Also, the W-2 program determines how a customer's strengths can be enhanced, employment obtained and maintained, while stabilizing the household income and guiding the family to self-sufficiency.

W-2 customers may have complex circumstances and a Financial Employment Planner (FEP) develops an individual employability plan that isolates the household's employment barriers. These barriers could be transportation, education, training, physical or mental disabilities, or the care of a child under the age of 8 weeks. Customers enrolled in the W-2 Program are required to participate in specific activities designed to

guide them to employment. The customer will receive a monthly payment of $608.00 or $653.00 per month depending upon their employment placement.

The number of yearly participants in the 2012 W-2 program remains consistent because the participation requirements are intense and the customer's needs may be able to be met through other financial assistance programs in lieu of W-2.

Beginning in 2013, The W-2 program for Jefferson County customers is now administered by Forward Services Corporation based upon contract changes initiated by the State. Forward Services contact information is 920-674-2295 and they are located at 222 Wisconsin Drive Jefferson, WI. The website for the Department of Children and Families is www.dcf.wisconsin.gov.

Unduplicated W-2 Participants

	2010	2011	2012
Participants	58	63	65

* * *

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Director, *Kathi Cauley*

- **Administrative Services Division Manager, *Joan Daniel***

Maintenance, *Terry Gard*

Office Manager & Support Staff, *Donna Hollinger*

- **Aging and Disability Resource Division Manager, *Sue Torum***

Aging & Disability Resource Center, *Sharon Olson*

- **Behavioral Health Division Manager, *Kathi Cauley***

Community Support Program, *Marj Thorman*

Comprehensive Community Services, *Kim Propp*

Mental Illness/AODA, *Holly Pagel*

Lueder House, *Terri Jurczyk*

Medical Director, *Mel Haggart, M.D. – (Contracted)*

- **Child & Family Division Manager, *Brent Ruehlow***

Intake, *Laura Wagner*

Child Welfare, *Kevin Reilly*

Juvenile Justice Integrated Services, *Jessica Godek*

Birth to Three, Busy Bees Preschool, *Diane Bazylewicz*

Wraparound, *Barb Gang*

- **Economic Support Division Manager, *Jill Johnson***

W-2 Programs, *Sandy Torgerson*

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Barb Mottl
Mary Ostrander
Dawn Renz
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INFORMATION & ACKNOWLEDGEMENTS

If you have any questions regarding anything in this report or you know someone who is in need of our services, please contact us at the following address:

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1541 Annex Rd, Jefferson, WI 53549
Phone Number: 920-674-3105
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TDD Number: 920-674-5011
Website: www.jeffersoncountywi.gov

AGING & DISABILITY RESOURCE DIVISION
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